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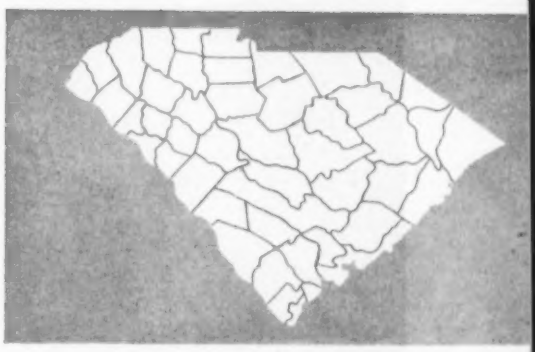

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Ascariasis And The Respiratory Tract

(TROPICAL EOSINOPHILIA)

KERRISON JUNIPER, JR., M. D.
M. W. BEACH, M. D.

Since ascariasis is so frequently seen in the outpatient clinic and pediatric wards of Roper Hospital, and since they produce many gastrointestinal and respiratory disturbances, we thought that it might be worthwhile to review some of the literature with special reference to the respiratory tract, and to report two cases.

The Authors:

Dr. Juniper is serving an internship at The Roper Hospital, Charleston, South Carolina. He was graduated from Emory University School of Medicine in 1949.

Dr. Beach (Medical College of the State of S. C., Class of 1913) is Professor of Pediatrics at his Alma Mater.

Eosinophilia associated with pulmonary findings has been described frequently in the literature under the names of Loffler's syndrome and tropical eosinophilia.

Loffler's syndrome, as originally described by Loffler,[19] consists of:

1. Slight or no definable subjective symptoms;
2. Slight elevation of the temperature, eosinophilia, and uncommonly an irritative cough; and
3. Pulmonary infiltrations on x-ray which are fleeting.

In none of Loffler's 51 cases was the etiology definitely ascertained.

Tropical eosinophilia is similar to Loffler's syndrome in that there is eosinophilia and pulmonary infiltrations; however, tropical eosinophilia is different because of more severe symptoms, a more protracted duration, and frequently the presence of an etiological agent. Wilson[34] and Hodes and Wood[15] state that tropical eosinophilia differs from the primary allergic group of disorders by the absence of a family history of allergy and the presence of fever, leukocytosis, splenomegaly, and characteristic shadows on x-ray; it also responds to treatment with arsenicals, often dramatically.

Many articles have suggested the following causes of Loffler's syndrome and tropical eosinophilia:

Acariasis	Hookworm
Ascaris	Microfilariae
Azosulfamide	Pollens
Bronchial Asthma	Strongyloides
Brucellosis	Taenia Saginata
Coccidiomycosis	Trichinosis
Creeping Eruption	Trichuris Trichiura
Endamoeba Hystolytica	Tuberculosis
Fasciola Hepatica	

Ascaris is often mentioned as a possible etiological agent in the eosinophilic lung syndromes. It is common knowledge that, when embryonated eggs of ascaris lumbricoides are ingested by the human, the larvae hatch and penetrate the wall of the small intestine and gain entrance to the lymphatics and portal veins. De Rivas[7] is an exception—he states that the development of the embryo into a larva and adult directly in the small intestine is probably the rule. Other authorities,[5, 26, 29, 36] however, agree that the larvae generally penetrate the intestinal wall and enter either the lymphatics or tributaries of the portal vein. Yoshida[36] believes that the larvae pass through the intestinal wall to the abdominal cavity and migrate to various organs by direct penetration rather than by way of either the blood or lymph streams. The larvae which enter the lymphatics may become caught in the interposed lymph nodes and eventually perish; a few may gain entrance to the venous circulation via the lymphatic ducts. The larvae in the portal vein reach the liver, where some may lodge in the capillaries and penetrate the alveoli, finally migrating up the bronchial tree and then down the esophagus to the intestines where they develop into adults and live for approximately one year before dying.

Stewart[28] is said to be the first to demonstrate the

presence of ascaris suis larvae in the liver and lungs of rats and mice.

Ransom[26] infected 100 animals, mostly guinea pigs, and followed the migration of the larvae by pathological studies. He was able to demonstrate larvae commonly in the portal vein 1-2 days after infection—as many as 437 larvae in one case. The larvae were numerous in the liver within 24 hours, but no larvae could be found in the bile ducts. Many of the larvae appeared to be stopped by the capillaries in the liver, where they accumulate; however, no larvae could be found in the liver 7 days after infection. Sections of the liver showed that the larvae passed across the lobules from the interlobular to the central veins. Larvae were also demonstrated in the vena cava and right ventricle. From 4 - 12 days after infection larvae could almost invariably be found in the lungs. Larvae of the usual maximum length attained in the lungs (1.7 mm) were seen 7 days after infection. By 11 - 12 days after infection most of the larvae had moved on into the intestine. Larvae have been found, in the course of their migration, in the peripheral lymph nodes, thyroid, thymus, kidney, spleen, brain, and the pleural and abdominal cavities. Strong[29] states that the larvae can even pass through the placenta into the fetus.

A few experiments have been carried out on human beings:

Koino,[18] in 1922, fed 500 ascaris suis eggs to a healthy adult male. Nine days later the subject developed fever, chills, headache, cough, chest pain, dyspnea, and rapid respiration. Ten days after infection a few rales were heard. The symptoms persisted for eight days and then disappeared.

Following this, Koino ingested 2,000 eggs. In six days he developed fever, chills, headache, malaise, a productive cough, and rapid respiration. His sputum contained as many as 178 larvae in one day, and larvae could be demonstrated in the sputum for 6 days. Blood appeared in the sputum on several occasions. Two days after the onset of the symptoms rales and dullness to percussion were present over the chest. The signs and symptoms disappeared in 8 days. Fifty days later 667 adult ascaris were recovered in the stools following anthelmintic therapy.

Elkeles and Butler[8] state that Vogel and Minning also produced eosinophilia and transient lung infiltrations by feeding humans ascaris - containing soil.

Ransom[25] states that over 50 years ago a German physician named Mosler fed ascaris eggs in numbers as large as several dozen to healthy children of various ages. Several days after infection some of the children developed fever and had some respiratory difficulty. Mosler did not attribute the symptoms to the ascaris.

Ransom[25] also records another human experiment carried out by Lutz in South America upon an adult volunteer. A total of about 100 viable eggs were ingested over a course of several days. Several days later the subject suffered from acid dyspepsia, repeated vomiting, and a slight remittent fever. An unusually severe bronchitis soon developed. These symptoms were gradually replaced by the symptoms of an intestinal catarrh. Following anthelminthic therapy 35 immature ascarids were passed in the feces.

Moeller[20] was able to produce multiple fleeting pulmonary infiltrations and associated eosinophilia in himself by eating ascaris ova.

Several clinical studies are on record in which the authors believed that ascaris larvae passing through the lung were responsible for the pulmonary findings, [17, 24, 25, 30, 31, 33]

Birk[3] reported a case of chronic tracheal catarrh in a 10 year old child in which he was able to demonstrate ascaris larvae in the sputum. This child did not have any fever but did have an eosinophilia, ascaris ova in the stool, and a cutaneous desquamation on the palms and soles. No abnormal pulmonary findings were reported. The tracheal catarrh lasted for 4 months and finally cleared up with treatment for intestinal ascariasis.

The damage caused by the passage of ascaris larvae from the capillaries into the alveoli is due to two factors: 1. the mechanical trauma, and 2. the allergic reaction induced by the presence of the larvae.

The mechanical factor is self explanatory. The allergic factor is supported by the high eosinophilia seen during the passage of the larvae through the lung.[2] Girges[10] made a detailed study of the body fluids of ascarids and found that toxins were present which caused acute allergic reactions in both animals and man. Davidson, Baron, and Walzer[6] found evidence that suggested that there was a more rapid rate of experimental active sensitization with ascaris lumbricoides antigen in the negro race than in the white.

Craig and Faust[5] found that petechial hemorrhage occurred even when a few larvae were passing through the lung; in heavier infestations small pools of blood may accumulate in the alveoli and smaller bronchioles and edema develops. A local infiltration of polys and eosinophiles with a serous exudate plugs up the air spaces and results in a consolidation of the involved lobules. In extreme cases complete consilidation of the lobes may occur. This was demonstrated experimentally by Koino brothers.[18]

Speaking of lung infiltration with eosinophilia in general, and not in proven ascariasis, Gravensen[12] points out that the allergic reaction which occurs in the lung is due to a hypersensitivity of the interstitial tissue and not of the bronchiolar portion. Elkeles and Butler[8] found that Von Meyenburg autopsied 4 soldiers who died accidentally and found an eosinophilic bronchitis and bronchiolitis and eosinophilic infiltrations of the liver. Bayley, Lindberg, and Bag-

genstoss[1] report an autopsy on one case of Loffler's syndrome in which they found large numbers of eosinophiles in the pneumonic exudate with organization of the exudate with fibrosis and giant cells, and the presence of peculiar granulomatous lesions and necrotizing arteritis and phlebitis.

Case History: K.T.—Colored Male

Family History: Non contributory, two siblings alive and well. Mother received rapid treatment for syphilis prior to birth of sibling. Wassermann, negative.

Past History: Full term spontaneously delivered infant who weighed 6½ lbs. at birth; breast fed.

Present Illness: This patient was seen in the clinic at two weeks of age when he had an upper respiratory infection which soon subsided. When four months of age, this baby again visited the clinic with an acute URI and gastric upset; however, he did not appear to be very ill. T. 98°. Physical examination revealed a well developed and nourished infant weighing 17 lbs.; there was a mild degree of respiratory infection and scabies, for which he received appropriate therapy.

About ten months later, at the age of 14 months, patient visited the clinic again on account of cold, cough, and fever of one weeks' duration. T. 101°. Physical examination was negative except for an otitis media and a few rales which were heard throughout the two sides.

Laboratory Data: Hb. 6.5 WBC 21,700 56% Polys 41% Lymphs 1% Eos.

He was seen on four more occasions during the next three weeks with similar findings in the chest; however, the otitis media had disappeared. At none of these visits were there any fine rales or signs of consolidation. Cough and fever continued to be prominent symptoms during the night. The child was put on Aldiazol in October, 1948. Subsequent white counts on two occasions showed 16,000 with 3 - 4% eosinophiles. The patient continued to have rhonchi over both lung fields when discharged.

The child was seen again in February, 1949, with fever, cough, and cold. Diagnosis: Bronchitis.

In June, 1949, he was seen again with fever, diarrhea, and cough. At this visit he had pharyngitis, scattered rales over both lung fields, generalized lymphadenopathy, and a palpable spleen. At a later date the diagnosis of measles was made.

On October 31, 1949, he was seen with a history of diarrhea (during which time one ascaris was passed in the stool), cold, cough, fever, and a runny nose of two weeks duration. The sputum was described as being yellowish thick mucus but did not contain any blood. T. 100°. Fine moist rales with harsh breath sounds were present over both lung fields. There were no signs of consolidation. A mild otitis media and pharyngitis were also present. The liver and spleen were both palpated 2 cm. below the costal margin. During this visit it was found that the child had a desire to eat dirt. There was no history of exposure to tuberculosis.

Laboratory studies showed a negative Wassermann, Kline was doubtful, + tuberculin (1:1000), Hb. 7 gms., RBC 4.06, sickling negative, 29,600 WBC with 26% Polys, 39% Lymphs, and 35% Eos. Urine was negative. Stools were positive for ova of ascaris lumbricoides. Sputum studies were negative for T. B. and positive for ascaris larva—Figure 1. The child has been seen eight times during the past month and has had weekly CBCs and x-rays of the chest — Figures 2-5.

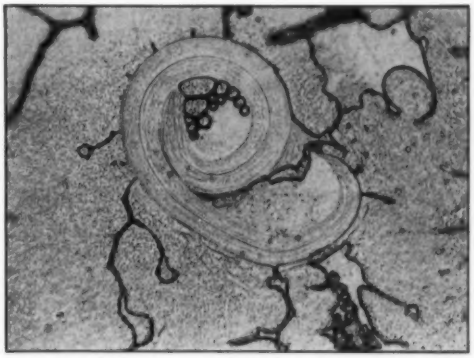

Figure 1—Ascaris Larvae Found in Sputum. Wet preparation, unstained. X900

Figure 2—November 9, 1949—Diffuse Haziness Around Each Hilum With Small Focal Areas of Increased Density.

This little patient has been treated on three occasions, each with 0.2 gms. of Hexylresorcinol, and has passed several round worms after each treatment.

November, 1949: He has continued to have some ronchi. Since receiving this form of therapy, mother

Figure 3—November 11, 1949—Small Areas of Increased Density Are More Pronounced.

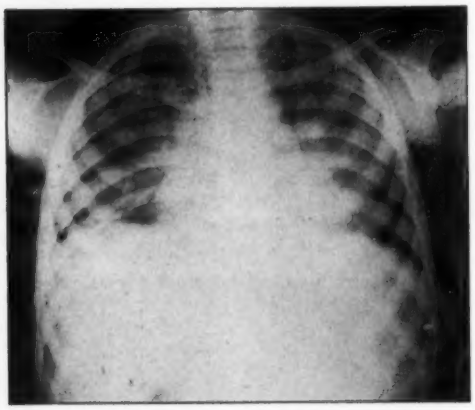

Figure 4—November 22, 1949—Diffuse Haziness of Perihilar Areas Without Consolidation.

states that she has noticed a marked improvement in the child's appetite and that he sleeps better and plays more vigorously. He no longer has the desire to eat dirt. While this patient appears clinically well, he continues to pass ascaris ova in his stools and to have some abnormal x-ray findings.

Discussion: The case presented fits the description of tropical eosinophilia. It is called tropical eosinophilia rather than Loffler's syndrome because of the prominent and prolonged clinical findings and because we believe that the migration of the ascaris larvae were responsible for these clinical findings. In Loffler's cases parasites had been ruled out as possible etiological factors. The high eosinophilia would seem to indicate that the allergic factor was important in producing such striking clinical findings.

Figure 5—November 29, 1949—Continued Hilar Enlargement With Accentuated Markings. Findings Less Pronounced Than On Any Of The Previous Examinations.

This child, through the habit of eating dirt, probably ingested many more ascaris ova than does usually occur. It is frequently stated in the literature that ascaris larvae can be found in the sputum in cases of ascariasis. A fairly extensive search of the literature revealed that larvae had been demonstrated in the sputum in human ascariasis in only one non-experimental case.[3] Perhaps this is due to the inadequacy with which the sputum was examined. We found only one larva in the sputum of this child.

T. E.—Clinical Record

Past History: Premature infant born at home 12/12/41 and admitted to the hospital where he remained for two months. Birth weight was 4 pounds 11 oz. On admission left-sided facial paralysis and icterus neonatorum were present. Progress as a premature was satisfactory; facial paralysis was still present when discharged.

Infant was seen in clinic 3/4/42 at the age of 3 months because of a cold. Mild URI present with left inguinal hernia and abdominal distention.

Frequent visits revealed a negative Kline; the URI had cleared up; left facial paralysis continued to be present at each clinic visit. Weight gain was slow at first but became satisfactory on last visits. No clinic record after 8/20/42.

Patient was seen in the emergency room on 10/26/47 and died before a definite diagnosis could be made. A profound anemia was noted and a provisional diagnosis of encephalopathy and sickle cell anemia was made.

Family History: Mother had taken 14 arm and hip injections while carrying this child. Congenital lues considered.

T. E. (47-212, 160, 714)—Necropsy

Gross: There was moderate dilatation of heart, particularly of the right ventricle. Pleural adhesions were present on the right. The lungs were diffusely congested and edematous, but no areas of consolidation were detected.

The intestines contained numerous adult ascarids. The liver showed foci of subcapsular hemorrhagic mottling.

Microscopic: Sections of lung showed the most marked changes. Numerous eosinophiles were present in the alveoli and their walls. These were of sufficient number in some areas to constitute an eosinophilic pneumonia. Two foreign body granulomas were found. One of these consisted of a conglomeration of giant and epithelioid cells about pink amorphous material. The other was composed of a nodule of epithelioid cells surrounding a larva (Figure 6 and 7).

There were foci of fatty degeneration within the liver and the portal areas were staffed with eosinophiles. These eosinophilic collections extended into the capsular tissues and were so abundant in the portal triads as to produce marked enlargement of these areas.

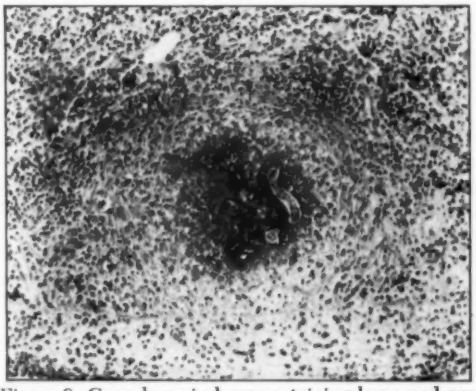

Figure 6—Granuloma in lung containing larva and surrounded by heavy eosinophilic infiltration. Hematoxylin and Eosin, X150.

An unusual number of eosinophiles were present within the lymph nodes and spleen.

Pathological Diagnosis: Ascariasis with acute lobular pneumonia. Granulomas of lung with larva, probably ascaris.

The necropsy case presented seems to fit into the tropical eosinophilia group and it is included in this report because the cause seems to be ascaris infestation. It would seem possible that an acute anaphactoid reaction may have been responsible for the child's death.

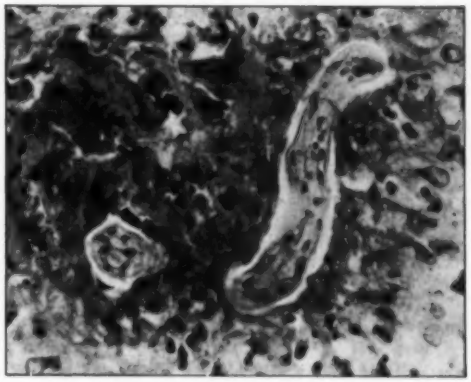

Figure 7—Higher magnification of larva shown in Figure I. Hematoxylin and Eosin, X750.

BIBLIOGRAPHY

1. Bayley, E. C., D. O. N. Lindberg, and A. H. Baggenstoss: "Loffler's Syndrome," Arch. Path. 40:376, 1945.
2. Bergstrand, H.: "Morphological Equivalents in Polyarthritis Rheumatica, Periarteritis Nodosa, Transient Eosinophilic Infiltration of the Lung and Other Allergic Syndromes," J. Path. and Bact. 58:399, 1946.
3. Birk, W.: "The Demonstration of Nematode Larvae of Ascaris Lumbricoides in the Sputum," Deutsche Med. Wchnschr 59: 841, 1933.
4. Blacklock, B., and S. Adler: "The Pathological Effects Produced by Strongyloides in a Chimpanzee," Ann. Trop. Med. and Parasitology. 16:283, 1922.
5. Craig and Faust: *Clinical Parasitology*, Lea and Febiger, 1937.
6. Davidson, A. G., B. Baron, and M. Walzer: "Factors Influencing Reagin Formation in Experimental Human Sensitization to Ascaris Lumbricoides Antigen," J. Allergy 18:359, 1947.
7. De Rivas, D.: *Clinical Parasitology and Tropical Medicine*, Lea and Febiger, 1935.
8. Elkeles, A., and N. R. Butler: "Transitory Pulmonary Infiltrations and Apical Cavitation Associated with Eosinophilia," Brit. J. Radiol 19:572.
9. Font, J. H.: "The Eosinophilic Lung," Ann. Otol., Rhin. & Laryng. 56:804, 1947.
10. Girges, R.: "Pathogenic Factors in Ascariasis," J. Trop. Med. and Hyg. 37:209, 1934.
11. Gottdiener: "Loffler's Syndrome," New York State J. Med. 45:2179.
12. Gravensen, P. B.: "Transitory Lung Infiltrations with Eosinophilia," Acta Med. Scandinav. 96:523, 1938.
13. Henderson, A. T. and C. B. Pierce: "Transitory Focal Pulmonary Edema and Eosinophilia," Am. J. Roentgenol. 58:391.
14. Hendon, J. R.: "Loffler's Syndrome," Am. Pract. 2:592, 1948.
15. Hodes and Wood: "Eosinophilic Lung," Am. J. M. Sc. 210:288.
16. Irwin, J. W.: "Tropical Eosinophilia," Ann. Int. Med. 25:329, 1946.
17. Keller, A. E., H. T. Hillstrom, and R. S. Gass: "The Lungs of Children with Ascaris," J. A. M. A. 99:1249, 1932.
18. Koino, S.: Japan M. World 2:317, 1922.
19. Loffler: "Fleeting Pulmonary Infiltration with Eosinophilia," Schweiz. Med. Wchnschr 45:1069.
20. Moeller, C. Frimodt, and R. M. Barton: "A

Pseudo-tuberculous Condition Associated with Eosinophilia," Indian M. Gaz. 75:607, 1940.
21. Peabody, J. W.: "Transitory Migratory Pulmonary Infiltrations Associated with Eosinophilia," Dis. of Chest 10:391, 1944.
22. Pearlman, A. W.: "Loffler's Syndrome, "Am. J. Roentgenol. 58:75, 1947.
23. Perlingiero, J. G., and P. Gyorgy: "Chronic Eosinophilia," Am. J. Dis. Child. 73:34, 1947.
24. Plaschkes, S. J.: "Ascaris-Pneumonia," Acta. Med. Orient. 5:80, 1946.
25. Ransom, B. H.: "A Newly Recognized Cause of Pulmonary Disease—Ascaris Lumbricoides," J. A. M. A. 73:1210, 1919.
26. Ransom, B. H., and E. B. Cram: "The Course of Migration of Ascaris Larvae," Am. J. Trop. Med. 1:129, 1921.
27. Spector, H. I.: "Loffler's Syndrome," Dis. of Chest 11:380, 1945.
28. Stewart, F. H.: Parasitology 9:213.
29. Strong: *Tropical Diseases.*
30. Swartzwelder, J. C.: "Clinical Ascariasis," Am. J. Dis. Child. 72:173, 1946.
31. Van der Sar: "Pulmonary Acariasis," Am. Rev. Tuberc. 53:440.
32. Weber, F. P.: "Transitory Pulmonary Infiltration with Blood Eosinophilia," Brit. J. Child. Dis. 36:15, 1939.
33. Wegman, M. E., R. V. Platou, A. Sullivan: Case 2. Ascariasis, Clinical Conference (Charity Hosp. of Louisiana at New Orleans), J. Pediat. 35:249, 1949.
34. Wilson, H. T. H.: "Tropical Eosinophilia in East Africa," Brit. M. J. 1:801, 1947.
35. Wright, D. O., and E. M. Gold: "Loffler's Syndrome Associated with Creeping Eruption," Arch. Int. Med. 78:303, 1946.
36. Yoshida, S.: "On the Migrating Course of Ascarid Larvae in the Body of the Host," J. Parasitology 6:19, 1920.
37. Editorial: "Transient Pulmonary Infiltrations Associated with Eosinophilia," J. A. M. A. 126:837, 1944.
38. "Ascaris Lumbricoides" from *Medical Protozoology and Helminthology* — Naval Medical School, National Naval Medical Center, Bethesda, Maryland. September, 1944.

Cancer Of The Genito-Urinary System

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The purpose of a lecture on such a wide subject, "Cancer of the Genito-Urinary System," can only be to encourage the application of careful systematic analysis of symptoms and signs employed in other fields of medicine and surgery.

The taking of a medical history is an art and a very personal experience. It may be drudgery but it can be pleasant, stimulating and satisfying practice. From evaluation of the history, I always try to arrive at the most likely diagnosis. This impression may be confirmed or modified by the results of the complete physical examination and further developed by special urological diagnostic procedures.

Pain, mass and hematuria are the well known symptoms of cancer of the urinary tract. Pain is a late symptom associated with large or invasive tumors or obstructive lesions. Mass is usually associated with renal cortical neoplasia. Hematuria may occur as an early or late symptom and usually is the reason for urological consultation. The duration of hematuria is not a good indication of the life history of the tumor. If we must wait for the symptoms of pain, mass and hematuria to establish a diagnosis, the cure rate will be very low.

We must not pass over the other well known symptoms of cancer; fatigue, weight loss and principally anaemia. Among eight patients referred to me for complete urological study because of anemia during the past six months, the diagnosis of hypernephroma was established in two instances, primary hydronephrosis with pyelonephritis in two, carcinoma of the urinary bladder in one, carcinoma of the prostate with metastasis in one and in the other two, no cause for the anaemia could be found in the urinary tract. Neither of the patients with hypernephroma had hematuria, nor was there evidence of urinary blood loss in any but the patient with bladder cancer. Another patient with gross hematuria, severe anaemia and arterial hypertension had as a presumtive diagnosis squamous cell carcinoma of the right ureter. There appeared to be narrowing of the lower third of the ureter without filling defect. On ureteral catheterization, when no blood was seen passing from the ureter, gross bleeding followed passage of the catheter 10 cms. twice. Nephro-ureterectomy was performed. On exposure of the kidney a 2 cm. tumor of the renal cortex was noted. The pathological diagnosis was hemorrhagic infarct of the kidney, ureteral stricture with ureteritis, secondary to pelvic inflammatory disease.

The symptom of hematuria requires further evaluation. Blood, microscopic or gross, passed throughout urination may come from lesions of the kidneys, ureters or bladder. Blood at the end of urination means bladder tumor until ruled out by painstaking cystoscopic observation. Blood at the onset of urination is usually associated with lesions of the posterior urethra or prostate. Blood at the meatus without passage of urine indicates a lesion of the anterior urethra.

Hematuria from carcinoma of the prostate is a late symptom with ulceration of the urethra or neck of the

(Presented at Alumni Seminar—Nov. 1949).

bladder. Hematuria is a much more common symptom of benign prostatic enlargement, the blood being passed in the urine or squeezed out from the dilated veins on the surface of the adenoma at the beginning and/or end of urination. Hematuria in a patient in his sixties or seventies with associated symptoms of prostatism requires further evaluation by cystoscopic observation and radiologic investigation of the upper urinary tract. I have seen hypernephroma and benign prostatism concomitant on four occasions. I well recall the case of a French colonel who had had two previous transurethral resections of the prostate and was admitted to Walter Reed General Hospital because of gross hematuria. Cystoscopy revealed bleeding from the prostatic fossa. The ureteral orifices could not be visualized. Excretory urography revealed a normal left kidney and ureter. The right kidney was non-functioning. He was rather obese and no mass could be palpated. After a third transurethral resection was accomplished, I could see blood passing from the right ureter. The diagnosis of renal cortical tumor of a congenital pelvic kidney was made by retrograde pyelography and the tumor removed with great difficulty. He lived three years, returned to France and died of an obstructing carcinoma of the oesophagus.

I think it would be wise to investigate the urinary tract of patients with anaemia. Certainly hematuria is cause for thorough urological work-up. There are other causes of hematuria, calculus, acute infection, obstructive, lesions of the prostate or ureters, nephritis, renal epistaxis associated with hypertension and blood dyscrasias, but cancer must be ruled out. Eighteen years ago I made the very rash statement "The only thing essential about hematuria is the necessity for a thorough urological investigation." Since that time I have been repeatedly embarrassed by negative findings which require repeated examination again and again until the cause of the bleeding is found.

The value of the scout film of the abdomen, including kidneys, ureters and bladder is well established. Renal cortical masses with or without bowel displacement may be visualized. Calculus can be ruled out in the great majority of instances. By means of excretory urography many small tumors of the urinary tract are visualized. Whereas this is of great value to the patient in bringing about early diagnosis, this method of examination may cause great difficulty for the radiologist and urologist in the interpretation of the x-ray findings. It is frequently necessary to have retrograde studies to rule out or confirm impressions made from excretory urograms.

Renal cortical tumors are covered in two categories; the carcinoma typified by the so-called hypernephroma or Grawitz tumor, the mixed tumors represented by the adenomyofibrosarcoma or Wilms' tumor. Carcinoma of the kidney can occur at any age from youth to senility. The Wilms' tumor is practically limited to children and adolescents. Hypernephroma presents hematuria, pain and mass as cardinal symptoms in that order, while mass, pain and hematuria typify Wilms' tumors. The diagnosis of renal cortical tumor is made by pyelography, either by the retrograde or excretory method. Differentiation between solitary or multiple cortical cysts and tumor is most difficult. Everyone of great urological experience has made this diagnostic error. Therefore, we explore or remove renal masses. Confronted with the problem of diagnosis of an upper quadrant mass, the practitioner must decide whether to examine the urinary tract or the bowel first. Renal cortical masses usually present anteriorly below the costal margin while perirenal masses, such as abscesses or extravasations bulge the flank. The scout film will give aid for the decision. Obliteration of or enlargement of the renal shadow, obliteration of the psoas shadow, anterior or medial displacement of the large bowel, gas shadows and spinal curvature toward the mass are presumptive signs of renal tumor. When indoubt I would do excretory or retrograde urograms before investigating the gastro-intestinal tract with gallbladder visualization or barium meal or enemata. This is a time saving maneuver since diodrast is promptly expelled while days are required for complete evacuation of the barium.

Until other and adequate measures are developed for treatment of cancer, surgery stands as the only effective method of cure. Nephrectomy for renal cortical tumor is the accepted procedure but I would like to point out that a simple enucleation of the mass is inadequate. Wide exposure by incision and rib resection must be attained in order to remove not only the tumor but all of the perirenal fat. The vessels should be divided and ligated before the tumor is handled. Metastatic extensions into the veins must be removed. The cure rate for renal carcinoma and for Wilms' tumor is dependent on an early diagnosis, adequate excision, and also upon the type of tumor. Some renal carcinomas of the Grawitz type are much more amenable to surgery than others. Radiation may prove very valuable. Shrinkage of large tumors before surgery may be required but the usual dosage for hypernephroma is inadequate for cure. Using 1,000,000 volt radiation, the cure rate may be increased but damage to surrounding structures may result.

The cardinal symptom of tumor of transitional epithelium involving kidney pelvis, ureter or bladder is hematuria. Pain indicating ureteral obstruction is produced by tumor growth or the presence of clots. The diagnosis is made by cystoscopic observation and/or pyelography. Transitional cell tumors are rightly considered malignant regardless of their microscopic appearance. Even the benign tumors tend to recur by either implantation or new tumor growth. Infiltration of the tumor into the submucosa or into the muscularis is a grave situation. Squamous metaplasia is a bad prognostic sign. I do not know of any cures of squamous carcinoma of transitional epithelial origin.

Treatment of tumor of the renal pelvis or ureter is by nephro-ureterectomy followed by routine periodic reexamination of the bladder for recurrence and new tumor growth. Radium may be effective but the dosage must be great, probably 10,000 r. More conservative measures, such as partial ureterectomy, may be indicated for patients with a solitary kidney but this is not good surgery for the ordinary ureteral or pelvic tumor.

The cardinal symptom of tumor of the urinary bladder is terminal hematuria. Occasionally the total voided specimen is bloody. Pain, except for dysuria with passage of clots, is a grave sign in bladder cancer. Nocturia and frequency, evidence of diminished bladder capacity with hematuria in the absence of other symptoms of prostatic obstruction is a symptom complex commonly associated with infiltrating cancer of the bladder.

The cystoscope is the instrument of precision for the diagnosis of bladder tumor. With rare exception, cystoscopy is indicated for all patients with hematuria. While on military service, I was ordered by the Surgeon General to write a memorandum on cystoscopy for the use of the uninitiated. I wrote one sentence. "Cystoscopy is experienced observation of the urinary bladder by means of endoscopic instruments." Although versed in the art of manipulating similar instruments, I would not attempt gastroscopy because of lack of experience. Cystoscopy is a job for the initiated and experienced.

As a guide for therapy and an aid for prognosis, bladder tumors are conveniently divided into infiltrating and non-infiltrating lesions. Infiltrating tumors frequently metastasize, whereas non-infiltrating lesions do not; however, the incidence of recurrence or new tumor growth is considerable. Transurethral resection of papillary non-infiltrating tumors has practically supplanted fulgurating. By this means the tumor can be widely excised and good biopsy specimens obtained. Naturally some non-infiltrating tumors are too large for endoscopic resection and others are located in positions not amenable to transurethral surgery.

At any rate, periodic reexamination after endoscopic resection is imperative because of the high incidence of recurrence of incompletely resected tumors and to initiate treatment early for new tumor growths.

Cancer of the prostate is definitely on the increase due to extended longevity. Those of us who recall the protracted suffering of these patients in the 1920's strongly feel that radical surgery should be done when operable cases present themselves. The profession has been led into passive disregard for this malignancy by the spectacular response of inoperable lesions to hormone therapy. One of the great clinics of the country continues to provide statistical data on survival rates from conservative therapy of cancer of the prostate. Total prostatectomy is the only way to cure this malignancy.

The diagnosis of early cancer is made by digital rectal examination of the prostate. There are no symptoms. The family physician, the internist, the surgeon must recognize these small lesions by doing routine rectal examinations on all men over fifty years of age. Carcinoma of the prostate arises in the true prostatic tissue of the lamella, the glandular element extending from the level of the veru to the prostatic apex, behind the ejaculatory ducts to the base and laterally to the anterior commissure. Therefore, cancer of the prostate is readily palpable by rectum. Small lesions are prone to lie near the apex and toward the lateral border. Any firm, fixed nodular lesion should be suspected and appraised by an expert or biopsied for diagnosis. The differential diagnosis usually involves calculus which can be ruled out by x-ray examination, prostatitis and infarct, the latter two can only be ruled out by biopsy. The Silverman needle yields satisfactory specimens. I do not favor aspiration biopsy. My experience and impressions of the Papanicalou technique for staining prostatic secretion for malignant cells are that accurate digital rectal palpation is more certain and I have never had a positive laboratory report without positive clinical evidence of the malignancy. During the past year at Walter Reed General Hospital, 50% of the patients with prostatic cancer had radical surgery performed. This fact was due to a general order which implied that every officer and enlisted man should have a digital rectal examination done by an expert as part of his annual physical examination. As a result of the persistent efforts of Hugh Young and men trained by him, more cures of cancer of the prostate are being accomplsihed this year than ever before. The treatment of inoperable carcinoma of the prostate by estrogen therapy and castration is one of the great accomplishments of the past decade. I shall not go into the details of this profound subject.

Cancer of the penis is preventable by routine circumcision of all male infants shortly after birth. The exception to this rule of circumcision is the finding of a congenital anomaly of the penis, hypospadias or epispadias. I think urologists have erred in not properly classifying carcinoma of the penis. Some have only performed local excision, others have done radical surgery for all penile cancers. In my opinion carcinoma of the penis should be treated as we treat skin cancer; radical lymph node resection and amputation for squamous carcinoma, more conservative therapy for basal cell lesions.

Carcinoma of the urethra is a very rare condition. I do want to emphasize the advisability of having microscopic sections cut from urethral caruncles. I excise rather than fulgurate or dessicate caruncles. One unsuspected cancer was found by this routine section study from about forty patients.

Testis tumor only occurs in approximately 1–50,000 males per year. I am particularly interested in this subject because of my experience with over three

hundred of them in the past five years. The diagnosis should be easy if one would do routine bimanual palpation of the scrotal contents.

The usual symptom is painless swelling of the testis. Pain is a bad omen and fortunately rarely occurs. The increased scrotal weight may be the presenting symptom. Differential diagnosis is easy except in the case of gumma, thick walled or calcified hydrocele and hematocele. Torsion produces acute pain, the cord is shortened, the testis acutely tender, later undergoing atrophy. Hydroceles usually transmit light and both the testis and epididymis are within the hydrocele sac, whereas with testis tumor the thinned out or elongated epididymis can be palpated posterior to the tumor. Spermatocles should not be confused. They are attached to the globus major, the head of the epididymis, usually transmit some light and are rounded, well circumscribed. Hydroceles may be tapped to facilitate palpation. Blood in the hydrocele sac is a bad prognostic sign with testis tumor. Calcified hydrocele may be differentiated by x-ray studies. Gumma is of no importance; the testis is already destroyed and may as well be removed. When in doubt as to the diagnosis, surgical exploration of the scrotal contents is in order. Hormone bioassays are of some importance in differentiating types of tumor but this is not a differential diagnostic test.

Treatment of testis tumor should, in my opinion, be radical. The seminoma is a slow growing, relatively benign, metastasizing tumor, very radiosensitive. Here simple orchiectomy and x-ray therapy to the retroperitoneal lymph nodes and other metastatic lesions will suffice. But for all other malignant tumors, I remove the testis with the lymph drainage tract to the level of the renal pedicle. This operation carries no mortality, very little morbidity and is infinitely safer than high dosage of x-rays to the lymph nodes with the complicating factors of gastro-intestinal ulceration with constant danger of perforation.

Trichobezoar

A CASE REPORT

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By definition,[1] a bezoar is "a concretion formed in the stomach or intestine in ruminants and occasionally also in man. According to the substance forming the ball, we find trichobezoar or hair ball, trichophytobezoar consisting of hair and vegetable matter mixed, and phytobezoar or food ball." In Ochsner and Debakey[2] study up to 1938, 126 cases of phytobezoar were reported, and of this number, 73 per cent or 92 were caused by ingestion of persimmons and were called diospyrobezoar. Trichobezoars are much more common in females with age group of 10 to 19, while phytobezoars appear three times more often in males, with age group 50 to 59. In the same study, 184 cases of trichobezoar of various types were reported.

There is little to add to the numerous articles already written on this subject so far as symptoms and diagnosis are concerned. The purpose of this presentation is to add to the number of proviously reported cases, and more important, to demonstrate the large size of this concretion. So far as we know, this represents the largest bezoar on record.

CASE REPORT

(Case #13086): D. W., a white female, age 11, was admitted to the Spartanburg General Hospital February 22, 1949. Her complaints were anorexia, dyspepsia, generalized abdominal pain and malaise of several months' duration. Upon close questioning after the diagnosis was established, the parents of the child recalled incidents over a number of months when the patient ate twine, the sleeves of her sweaters, bits of her own hair, goat hair and other similar material.

Physical examination revealed a thin, poorly nourished, fairly well developed white female in no apparent distress. The only other positive finding was a large, firm, freely movable, easily palpable mass in the upper and mid abdomen.

X-ray examinations of the entire gastrointestinal tract were obtained and were reported as follows by Dr. H. E. Plenge, Hospital Radiologist:

"Examination of the large intestine, employing barium by enema, revealed the entire colon to fill readily during the fluoroscopy. The transverse segment of the colon assumes a curved shape adjacent to the soft tissue mass palpable in the upper abdomen. There is a large quantity of what appears to be food mixed with some gas in the usual position of the stomach. There is also a small quantity of gas scattered through several short segments of small intestine. No intrinsic lesion of the large intestine was noted." (See Fig. I)

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FIGURE I

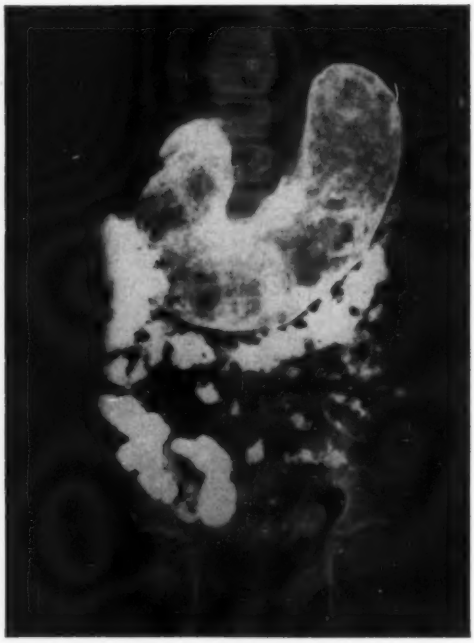

FIGURE II

"Examination of the upper gastrointestinal tract revealed the esophagus to be normal. There was rather marked enlargement of the stomach, which filled in a very unusual manner, as though the barium were infiltrating through crevices between retained food or foreign material. The stomach was quite firm and resisted change in shape by palpation. It is thought that the stomach contains a very large bezoar. The duodenal bulb appeared normal. At least half of the barium had passed out of the stomach at five hours, and made normal progress throughout the remainder of the intestinal tract. There is gross distortion of portions of the small intestinal pattern, the significance of which is not clear. It may be due to a deficiency state.

Impression: (1) Enlarged stomach containing a large quantity of foreign material.

(2) No intrinsic lesion demonstrated.

(3) Abnormal small bowel pattern."

(See Fig. II)

The patient was taken to the operating room on March 3, 1949 and explored through a transverse upper abdominal incision. Upon opening the stomach through a vertical incision in the midportion of the anterior surface, a foul smelling, black, hairy mass was seen. The stomach was dilated approximately twice its normal size and the mass formed a complete cast of that organ and extended into the duodenum and jejunum for a considerable distance. The mass was removed intact by delivering the inferior portion first and then sliding the larger superior part out. The extension was teased out intact by gentle traction and manipulation of the bowel. The gastric wall was closed in 2 layers using chromic intestinal sutures and interrupted cotton sutures. The abdominal wall was closed in layers with chromic catgut in the peritoneum and posterior fascial sheath, interrupted cotton #40 in the anterior fascia, and skin clips in the skin. The bezoar consisted largely of hair, twine, yarn, etc. and had the general configurations of the gastric lumen. It measured 26 centimeters in its longest axis and 12 centimeters in its greatest diameter and attached to the lower end of the mass was a 62 centimeter extension composed of hair and this measured 2 centimeters in its greatest diameter.

(See Fig. III)

The post-operative course was quite satisfactory, and the patient was discharged in excellent condition on March 12, 1949.

SUMMARY

A case of trichobezoar having fairly characteristic history and physical findings is reported. The positive diagnosis was established pre-operatively by radiologic examination. So far as we know, this is the

FIGURE III

largest bezoar on record.

BIBLIOGRAPHY

1. Steadman's Medical Dictionary, 15th Edition.
2. Debakey, M. and Ochsner, A.: Bezoars and Concretions: Comprehensive Review of the Literature with Analysis of 303 Collected Cases and Presentation of 8 Additional Cases. Surgery 4: 934-963, December, 1938; 5:132-160, January, 1939.
3. Watt, C. H. and Harner, J. W.: Bezoars Causing Acute Intestinal Obstruction. Annals of Surgery 1: 56-61, July, 1947.
4. Baumeister, Carl F. and Darling, Duane D.: Acute Intestinal Obstruction due to Orange Pulp Bezoar. Annals of Surgery 2: 251-252, August, 1947.
5. Smith, Lester A.: Hematemesis From Phytobezoar. American Journal of Surgery, 1933.
6. Lyons, Clinton G. and Cody, George L.: Bezoar. Radiology, August, 1938.
7. Carr, W. M.: A Case of Hairball. Radiology, July, 1924.
8. Rousing, C. M., Trichobezoar in the Stomach, Acta Radiologica, II, 1923, p. 491.
9. Peake, John Day: Trichobezoar or Hair Ball, Radiology 51: 816-819, December, 1948.

Fibrosarcoma Of The Kidney

A CASE REPORT

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FIBROSARCOMA OF THE KIDNEY

Sarcomas of the kidney have been variously grouped and subdivided into fibrosarcoma, round-celled sarcoma, fibromyosarcoma, liposarcoma and spindle-celled sarcoma. Less than 100 cases of all varieties of renal sarcoma appear in the literature. Less than one-third of this group may be classified as fibrosarcoma.

CASE REPORT

A 37 year old white male was admitted to the hospital on May 20, 1949, with the chief complaint of hematuria of three days duration, approximately two weeks before hospital admission .This was accompanied by moderate bilateral lumbar pain which radiated into the groin area. Since this time the patient had noted slight burning on urination on several occasions and had had nocturia one or two times for the two weeks period before admission. This symptom had never been previously noted. There was a history of eight pounds weight loss over the past three months period. System review was essentially normal. The family history was non-contributory.

Physical examination revealed a well nourished but poorly developed white male of the above-stated age. Blood presure was 120/70. No abdominal masses could be palpated nor were the kidneys palpable. External genitalia and rectal examination were essentially normal. There were no abnormal physical findings.

Urine culture from both kidneys revealed no growth. NPN was 32 mgs percent. Urinalysis was normal. Kahn was negative, and the admission blood count was within normal limits. Urine smear was negative for acid fast. bacilli.

X-ray of the chest on May 23, 1949, was not remarkable and x-ray study of the long bones showed no evidence of metastasis. Retrograde pyelograms (Figure 1) revealed the presence of an apparent mass within the right kidney substance which seemed to displace the upper and lower calices toward their respective poles. The picture was consistent with that

FIGURE 1

of a renal-celled carcinoma. Cystoscopy on May 23, 1949, revealed an essentially normal bladder except for mild injection of the trigone and some trabeculation of the bladder wall. There was no enlargement of the prostate and catheterization of both ureters was accomplished easily. Microscopic examination of the urine from each side was clear. A preoperative diagnosis of renal-celled carcinoma, kidney, right, was made and on May 27, 1949, a right nephrectomy was performed.

OPERATIVE TECHNIQUE: Skin incision was made directly over the long 12th rib, the posterior angle beginning approximately at the lateral border of the paravertebral muscles and extending anteriorly about two to three centimeters past the tip of the 12th rib in the direction toward the umbilicus. Incision of the latissimus dorsi and serratus posterior inferior muscles was accomplished at this level and the 12th rib resected. The attachments of the external and internal oblique muscles to the tip of the 12th rib bed were freed so that the oblique muscles might be retracted anteriorly and not incised, thus offering less chance for incisional hernia. The lumbodorsal fascia was then incised inferior and parallel to the rib bed and to the 12th intercostal nerve. Thus it was possible to reflect the peritoneum anteriorly and the diaphragm superiorly. The kidney was easily exposed after Gerota's fascia was opened and was freed with minimum manipulation under direct vision at the upper and lower poles. The renal veins were visualized without difficulty and there was no evidence of neoplastic involvement of the vessels of the pedicle or hilar area. The large vessels of the pedicle were clamped, cut, and ligated individually. The kidney was thickened in both the anterior-posterior and lateral diameters; a small area on the lateral border

FIGURE 2

in the mid portion of the kidney was characterized by densely adherent fatty tissue. However, the entire kidney was freed easily and apparently there was no extension through the capsule. The kidney was bivalved on completion of surgery so that a large encapsulated tumor could be distinguished in the mid portion of the kidney. It was of interest that the characteristic yellow color of renal cell carcinoma was noticeably absent at this time.

PATHOLOGY: The kidney weighed 260 grams (Figure 2). The central portion of the kidney was entirely replaced by a pinkish, gray appearing tumor approximately 7 centimeters in diameter. The calices were thin and distorted by the tumor. The surrounding kidney parenchyma was sharply defined. There was a large, clear fluid cyst, approximately 1½ cm. in diameter near the lower pole and several small cysts were noted in the upper pole of the kidney. Microscopic examination of sections taken of the tumor (Figure 3) showed large interlacing bundles of fusiform cells with thin nuclei. There were occasional areas of increased cellular formation and mitoses. The amount of stroma varied; however, it was of sufficient body so that the nuclei were seldom immediately adjacent to each other. There was marked hyalinization of the fibrous stroma. Many small blood vessels were present and all of these vessels were surrounded by a wide band of hyalinized collagen. Some tumor formation could be seen extending toward the hilar fat. Proximal tubules and glomerular spaces of the kidney contained densely eosinophilic protein. Diagnosis: Fibro-sarcoma, low grade, multiple, right kidney.

The postoperative course was entirely uneventful. Chest x-ray revealed no sign of atelectasis, postoperatively. The patient was seen in consultation by the Chief of the Tumor Service on June 6, 1949, and it was his opinion that the low grade of the tumor and the apparent adequate removal of the kidney would grant no indication for deep x-ray therapy as a prophylactic postoperative procedure. Massive dosage would have to be given and it certainly would not be indicated under these circumstances. The patient was discharged from the hospital on June 9, 1949, symptom-free, and was told to return for a recheck in approximately four months.

DISCUSSION

Fibrosarcoma apparently does not arise from fibroblasts. This process belongs to groups of tumors arising from nerve, muscle or fatty tissue. The present concensus of opinion is that primary sarcomas arise from the connective tissue of the kidney parenchyma rather than from the kidney capsule. This tumor was actually multiple within its capsule with bundles of smooth muscle forming divisions of the sarcomatous elements. The most striking pathological entity on microscopic examination of cut sections was that of perivascular and stromal hyalinization. Fibrosarcoma

FIGURE 3A

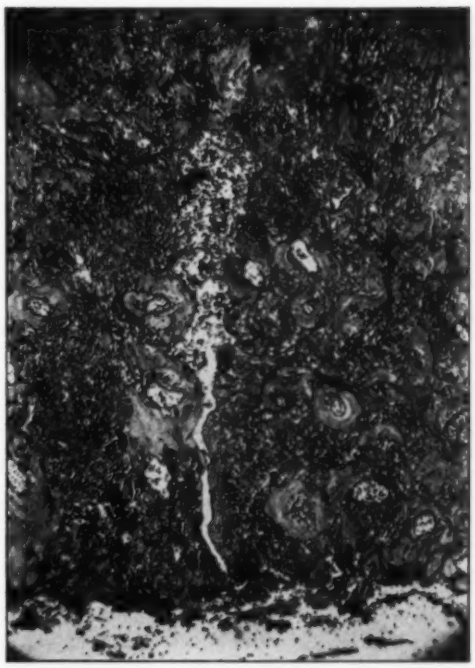

FIGURE 3B

has been defined as a tumor arising from connective tissue characterized by a tendency to recur after excision. This thus accounts for the consistently poor results of surgical treatment. The mechanism of spread of fibrosarcoma is of interest. Generally, extension occurs through the capsule with minor involvement of adjacent structures. Growth is in the direction of least resistance. A fibrosarcoma of low grade tends toward local infiltration before distant metastasis; consequently, lymphatic spread is a late manifestation of the disease. This path offers a true hazard for recurrence, particularly following surgery, for it is here that actually new tissue spaces are laid open and potential new lymphatic channels are offered. Always of paramount importance is local tumor implantation or spread of venous thrombi at the time of surgery. The prognosis is in general poor. The average survival time is less than twelve months following surgery. We know that radiation therapy is of little or no value in the treatment of fibrosarcoma. The low cure rate of this disease is undoubtedly due to the lack of early recognition, together with hesitancy for performing adequate radical surgery. The tumor alone cannot be removed with any great degree of success; there must be adequate surrounding normal tissues to accomplish an improved mortality rate. In this particular case I feel that the prognosis is more favorable than usual in view of the low grade of malignancy, the apparent absence of distant metastasis, and the lack of evidence of local infiltration beyond the kidney capsule.

SUMMARY

1. A case of fibrosarcoma of the kidney is reported.
2. A modified extraperitoneal approach to the kidney was utilized and has been described.
3. Postoperative deep x-ray therapy was not deemed necessary or advisable in this case.
4. Contrary to many previously reported cases we believe the prognosis in this instance to be favorable.

BIBLIOGRAPHY

1. Baurys, William: Sarcoma of the Kidney. The Guthrie Clinic Bulletin, Vol. 16; p. 65, October, 1946.
2. Carroll, Walter W.: Principles Involved in Surgical Therapy of "Encapsulated" Fibrosarcoma of Soft Tissues. Surgery, Gynecology and Obstetrics, 84: p. 703, 1947.
3. Hunt, V. C.: and Hager, B. H.: A Review of 271 Cases of Malignant Renal Neoplasms. Surg. Clin. N. Amer., Vol. IX, p. 149, Feb. 1929.
4. Judd, E. S. and Donald, J. M.: Sarcoma of the Kidney of the Adult. Ann. Surg., 96, p. 1028, 1932.
5. Sweetser, Theodore H.: The Surgical Approach to Renal and Other Retroperitoneal Tumors. J. Urol. 57: p. 651, 1947.

CANCER

Edited by R. W. POSTLETHWAIT, M.D., Charleston, S. C.

CARCINOMA OF THE ESOPHAGUS

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Carcinoma of the esophagus deserves particular interest and emphasis because of several factors. First, the impression has been formed that carcinoma of the esophagus has a higher incidence in this area than the frequency reported from other localities, although statistical studies have not been completed to verify this point. Whether the local diet, containing as it does large amounts of rice, poor oral hygiene or some other factor may be a determining element merits further investigation. Second, by the time exact diagnosis has been made, unfortunately the majority of the patients with carcinoma of the esophagus seen in this clinic are either inoperable or the tumor found to be non-resectable at the time of thoracotomy. Third, because of the remarkable advances which have been made in the treatment of carcinoma of the esophagus during the past ten years, both definitive operations and effective palliative procedures may now be offered these patients.

According to Ackerman and Regato,[1] approximately 2 per cent of all deaths from cancer in the United States are due to carcinoma of the esophagus. Ochsner and De Bakey[2] found about 5 per cent of all carcinomas to arise in the esophagus. Pack[3] included those carcinomas arising in or involving the cardia of the stomach and estimated that 10 per cent of all tumors of the esophagogastrointestinal tract were suitable for transthoracic esophagogastrostomy. A much higher incidence, and mainly in men, has been reported in China. Generally, the lesion is found predominently in men but Ahlbom[4] found 40 per cent of carcinomas of the mouth, pharynx and esophagus in women in Sweden, which he attributed to the frequency of the Plummer-Vinson syndrome (sideropenic anemia). Incidence is highest from 40 to 60 years of age but is not infrequent in the 30 to 40 year age group.

Nearly all malignant tumors arising in the esophagus are squamous cell carcinoma. Adenocarcinoma usually arises in the stomach and invades the esophagus by direct extension. Garlock[5] notes the peculiar pathologic differentiation that the adenocarcinoma arising in the stomach readily invades along the submucosa of the esophagus whereas the squamous cell lesion arising in the esophagus stops at the cardia. The lesion may be bulky and fungating but more frequently is an ulcerative process with marked tendency to invade along the submucosa. Invasion of important contiguous structures readily occurs. From the cervical portion of the esophagus, involvement of the larynx, trachea, thyroid and recurrent laryngeal nerves may occur. In the middle third of the esophagus, the trachea or a main bronchus, usually the left, the aortic arch and the prevertebral tissues are most frequently invaded. The pleura on either side, the pericardium, the descending aorta and the diaphragm are most likely to be the site of spread from the lower third of the esophagus. Lymph node involvement may occur to the anterior jugular or supraclavicular groups from upper third lesions, to mediastinal nodes from the middle third and to subdiaphragmatic nodes from the lower third. Metastases to nodes in the neck, however, are not infrequent from middle and lower third tumors just as the nodes along the lesser curvature of the stomach may be the site of metastases from middle and upper third lesions. Metastases to the liver, bone and kidneys may occur.

The duration of symptoms in carcinoma of the esophagus is often surprisingly brief. Dysphagia is the dominant and usually the first symptom. Not infrequently difficulty in swallowing has been present for less than a month and, although careful questioning may extend this period, dysphagia for more than a few months is unusual. This short duration may be difficult to explain in view of later demonstration of practically complete obstruction. More thorough mastication of food and change to a soft diet without conscious realization by the patient have been suggested as possible explanations.

Difficulty in swallowing usually begins for coarse foods and progresses until only liquids can be taken, and at times not even the latter. The onset may be sudden, due to block by a bolus of food or esophageal spasm, with later partial relief. Regurgitation occurs without nausea and the patients note the lack of a bitter taste to the vomitus. A sense of fullness or substernal pain may be present. Marked pain, particularly in the back, usually indicates invasion outside the esophagus. Cough may be due to aspiration but more often means invasion of the trachea or a bronchus. Paroxysms of cough after the ingestion of food suggests a tracheo-esophageal or broncho-esophageal fistula. Pulmonary suppuration with fever, hemoptysis and large amounts of sputum may follow. Compression or invasion of the recurrent laryngeal nerve will result in hoarseness. Occasionally the presenting symptoms may be due to metastases such as an enlarged node in the neck, or subdiaphragmatic lymph

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node or liver involvement causing vague abdominal complaints. Weight loss is usually rapid and may be considerable in amount.

Physical examination, other than the evidences of weight loss and dehydration, is usually uninformative insofar as exact diagnosis is concerned. Careful examination, however, must be performed to recognize metastatic lesions. Enlarged firm nodes in the neck or axilla, a mass in the epigastrium or an enlarged nodular liver may be found. Pulmonary infection subsequent to aspiration or to fistula formation may be evident.

Esophagoscopic and roentgenologic examination are most imperative for a patient in whom carcinoma of the esophagus is suspected. At the time of esophagoscopy, the level of the lesion may be determined, evidence of fixation sought and a specimen of tissue removed for microscopic study. With a lesion in the upper and middle third of the esophagus, bronchoscopy should also be performed because of the possibility of invasion of the trachea or bronchi. Study of the esophagus by fluoroscopy during swallowing of the barium mixture will usually demonstrate the point of obstruction. Irregular shelf-like projections into the lumen may be noted or an ulcer crater may be demonstrable. Wall rigidity due to infiltration is usually seen. The irregular constricted portion may give some indication of the extent of the lesion. Dilatation of the esophagus above the involved area is usually present but is infrequently marked, as seen in achalasia. Roentgen diagnosis of carcinoma of the cardiac portion of the stomach may require careful, repeated examinations. Sherman[6] noted in these lesions mucosal alteration to be a constant finding due to: infiltration causing fold stiffening, thinning and destruction; ulceration with fine irregularities; and mass formation showing fold erasure and change in course of the rugae.

Surgery offers the only hope of cure for these patients and also probably the most beneficial method of palliation. Following the first successful resection of the thoracic portion of the esophagus for carcinoma by Torek in 1913, more frequent efforts were made to remove these lesions. Only during the past ten years, however, have decided advances in surgery of the esophagus taken place. Garlock,[5] Sweet,[7] Adams and Phemister[8] with many others have contributed notably to these advances.

For lesons of the cervical esophagus, the Wookey operation or some modification has been most popular. The resected segment of the esophagus is replaced by a tube constructed from a skin flap which is turned in during the first stage. Recently, cases have been reported of resection of carcinoma of the cervical portion of the esophagus with reestablishment of continuity by cervical esophagogastrostomy.[9, 10, 11, 12] After transthoracic resection of a carcinoma of the middle third of the esophagus, the stomach is brought up into the thoracic cavity. Anastomosis between the stomach and esophagus is performed either above or below the arch of the aorta as necessitated by the height of the resection. In lesions of the lower third of the esophagus or the cardiac portion of the stomach, either the latter or a loop of jejunum may be brought into the chest for anastomosis after resection. Sweet[7] reported a resectability rate in the vicinity of 65 per cent. In a collected series of 1025 autopsies in cases of carcinoma of the esophagus Ochsner and De Bakey[2] found that 418 showed no evidence of metastasis, so that 40.7 per cent were resectable and probably a much higher percentage were operable.

In some patients in whom all of the tumor cannot be removed or distant metastases are found, resection and esophagogastrostomy is still warranted. In some patients, palliation may be obtained by local resection and end-to-end anastomosis of the esophagus, the feasibility of which was demonstrated by Parker and Brockington.[13] A return of the ability to swallow with the concomitant improved hydration and nutrition makes these patients much more comfortable for whatever time remains. Along the same lines, at times a short circuiting procedure to establish continuity around the lesion is advisable. In a number of patients, only gastrostomy can be offered.

As such a large number of these patients have far advanced lesions when first seen, results based on all patients entering with a diagnosis of carcinoma of the esophagus must be very poor. Only within the past few years have an appreciable group of these patients undergone resections with hope of cure, so that no significant series has yet been reported. It would appear, however, that even a very small five year survival percentage would be acceptable for patients with carcinoma of the esophagus.

1. Ackerman, L. V. and del Regato, J. A.: Cancer: Diagnosis, Treatment and Prognosis. C. V. Mosby Company, St. Louis, 1947.
2. Ochsner, A. and De Bakey, M.: Surgical Aspects of Carcinoma of the Esophagus. Surgery, 10:401-445, 1941.
3. Pack, G. T.: Introduction to Symposium on Cancer of the Esophagus and Gastric Cardia. Surgery, 23:867-873, 1948.
4. Ahlbom, H. E.: Simple Achlorhydric Anemia, Plummer-Vinson Syndrome, and Carcinoma of the Mouth, Pharynx and Oesophagus in Women. Brit. M. J., 2:331-333, 1936.
5. Garlock, J. H.: Progress in the Surgical Treatment of Carcinoma of the Esophagus and Upper Stomach. Surgery, 23:906-911, 1948.
6. Sherman, R. S.: The Roentgen Diagnosis of Cancer of the Cardiac Region of the Stomach. Surgery, 23:874-883, 1948.
7. Sweet, R. H.: The Treatment of Carcinoma of the Esophagus and Cardiac End of the Stomach by Surgical Extirpation. Surgery, 23:952-975, 1948.
8. Adams, W. E., and Phemister, D. B.: Carcinoma of the Lower Thoracic Esophagus; Report of a Successful Resection and Esophagogastrostomy. J. Thoracic Surg., 7:621-632, 1938.

9. Shefts, L. M. and Fischer, A.: Carcinoma of the Cervical Esophagus with One-Stage Total Esophageal Resection and Pharyngogastrostomy. Surgery, 25:849-861, 1949.
10. Wylie, R. H. and Frazell, E. L.: Cervical Esophagogastric Anastomosis Following Subtotal Resection of the Esophagus for Carcinoma. Ann. Surg., 130:1-8, 1949.
11. Brewer, L. A. III: One-Stage Resection of Carcinoma of the Cervical Esophagus with Subpharyngeal Esophagogastrostomy. Ann. Surg., 130:9-20, 1949.
12. Nissen, R.: Cervical Esophagogastrostomy Following Resection of Supra-Aortic Carcinoma of the Esophagus. Ann. Surg., 130:21-30, 1949.
13. Parker, E. F. and Brockington, W. S.: Esophageal Resection with End-to-end Anastomosis: Experimental and Clinical Observations. Ann. Surg., 129:588-605, 1949.

Figure 1. Patient A. R., 44 year old colored female, admitted July 14, 1949 because of dysphagia for two weeks and 35 pound weight loss. Barium swallow showed tumor at arch of aorta (A). Biopsy: squamous cell carcinoma. Operation August 3rd with resection of tumor and anastomosis of esophagus and stomach above clavicle (B).

Figure 2. Patient E. R., 50 year old colored female, admitted January 20, 1950 because of dysphagia for four weeks. Lesion in lower third of esophagus (A). Biopsy: squamous cell carcinoma. Operation January 30th. Metastases to nodes and liver found; palliative resection and anastomosis beneath arch of aorta (B).

NEWS ITEMS

Dr. Horace M. Whitworth of Greenville, has been promoted from Major to Lieutenant Colonel in the Medical Corps Reserve. Dr. Whitworth is Commanding Officer of the 306th Field Hospital Unit in the Greenville military subdistrict.

At a recent meeting of the South Carolina Society of Ophthalmology and Otholaryngology held in Greenville, the following officers were elected: President, Dr. W. M. Carpenter of Greenville; Vice President, Dr. J. B. Workman, Jr., of Columbia; Secretary-Treasurer, Dr. Roderick Macdonald of Rock Hill.

Dr. W. C. Cantey of Columbia, has been elected a vice president of the Tri-State Medical Association.

REVISED EDITION OF MOTION PICTURE REVIEWS NOW AVAILABLE

The Committee on Medical Motion Pictures of the American Medical Association has completed the second revised edition of the booklet entitled REVIEWS OF MEDICAL MOTION PICTURES. This booklet now contains 225 reviews of medical and health films reviewed in THE JOURNAL A. M. A. to January 1, 1950. Each film has been indexed according to subject matter. The purpose of these reviews is to provide a brief description and an evaluation of motion pictures which are available to the medical profession. Each film is reviewed by competent authorities and every effort has been made to publish frank, unbiased comments. Copies are available at a cost of 25 cents each from: ORDER DEPARTMENT, AMERICAN MEDICAL ASSOCIATION, 535 NORTH DEARBORN STREET, CHICAGO, 10, ILLINOIS.

The South Atlantic Association of Obstetricians and Gynecologists met at the Hotel Roanoke in Roanoke, Virginia on February 9, 10, and 11. The following officers were elected:

President
Dr. Lester A. Wilson, Medical College,
Charleston, South Carolina
President-Elect
Dr. E. D. Colvin, 1259 Clifton Road,
N. E., Atlanta, Georgia
Secretary-Treasurer
Dr. John C. Burwell, Jr., 416 Jefferson Building,
Greensboro, North Carolina

The next Annual Meeting for 1951 will be held at the Ormond Beach Hotel and Country Club, Ormond Beach, Florida, Thursday, Friday, and Saturday, February 8, 9, 10, 1951.

CORRESPONDENCE

THE SOUTH CAROLINA INDUSTRIAL COMMISSION

Columbia, S. C.

March 29, 1950

Dr. Julian Price, Secretary
South Carolina Medical Society
Florence, South Carolina
Dear Dr. Price:

The South Carolina Industrial Commission, with the cooperation of the Extension Division of the University of South Carolina, is sponsoring a one-day conference as a clinic on the problems of administering the Workmen's Compensation Law of South Carolina. The conference will be held at the University of South Carolina in Columbia, May 24, 1950. All persons who deal with the Industrial Commission, such as insurance adjusters and agents, personnel managers, doctors, nurses, labor representatives and others are invited to attend. There will be no solicitation for funds; nor any registration fee. A program of arrangements will be forwarded later.

We plan to study the requirements and functions of the various participants, looking forward to bringing about a better understanding and facilitating of claims.

It is highly important that your organization be represented. We would like very much to have as many doctors as possible, especially those engaged in industrial practice in workmen's compensation, to attend this conference. Would you therefore please notify each doctor of the State of this conference, and extend to them on our behalf an invitation to attend. Please request each doctor who plans to attend to notify us, so that details of the conference can be forwarded to them. Any other way that you desire the handling of notification and informing us of the doctors who will attend will meet with our approval.

This is very much your conference and is intended to assist you in your work with the Industrial Commission. We desire and need the benefit of your assistance in making necessary plans.

The Journal of the South Carolina Medical Association

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Please send in promptly notice of change of address, giving both old and new; always state whether the change is temporary or permanent. Original manuscripts, subject to approval by the Editor and the Editorial Board, are desired for publication in the Journal. They should be typewritten, double spaced, on 8½ x 11 paper. References should be complete, and only such as relate directly to statements quoted in the paper. Illustrations will be used as funds permit, or as authors are willing to bear the necessary increase in cost. Short original articles are preferred to long reviews.

Office of Publication: (In care of the Editor) ..... Florence, S. C.
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MAY, 1950

BLUE SHIELD

One of our principal goals was achieved and the Association took a great forward step recently when Blue Shield became an accomplished fact and the first contract was sold.

The South Carolina Medical Service Plan is the result of many years of work and is due to the combined efforts of many individuals. Special mention should be made of two individuals, however, since they were the leaders on the enterprise—Dr. J. D. Guess and Mr. M. L. Meadors. To these two men and to all those who worked with them, the Association owes a debt of gratitude.

To put the Plan into operation, fine as it is, is just the beginning. Now the people of South Carolina must be sold upon the value of this type of protection and be encouraged to purchase it upon a wider and wider scale. The Plan is one of medicine's answers to the problem of furnishing good medical care at a price the individual can afford to pay—and physicians should encourage all of their patients to consider securing the protection which Blue Cross has to offer.

ROLL OF HONOR

Concerned as we are with the future, it is only fitting that on occasion we should pause to pay tribute to those who have been our leaders in the past.

Recently we have been making a special study of the activities of our Association during the past ten years. As we scanned the pages of the Journal, as we read through the minutes of the House of Delegates and of the Council, as we pored over the reports of various committees, we were struck with the number of men whose names we found there, men who worked hard and valiantly for our organization, and yet men who are no longer with us and whose names are but a memory. We knew these men, some intimately, and admired them. They were real physicians and we are glad to publish their names one more time in this Journal, as our tribute to them:

A. Earle Boozer
Archibald Buist
George Bunch
Robert L. Cathcart
Jas. R. DesPortes
Curran B. Earle
Legrande Guerry
Edgar A. Hines
Douglas Jennings
J. Wilkie Jervey
Charles R. May
James McIntosh
Frank H. McLeod
James C. McLeod
D. Lesesne Smith
L. M. Stokes
Fred Williams
Robert Wilson

TWO NEW BOOKS

Two books have been sent in for review recently which we recommend unhesitatingly to any physician for reading in his moments of leisure.

The first is "Saw-ge-mah" (1), by Louis J. Gariepy. It is rare to find a novel written by a practicing surgeon and Dr. Gariepy is certainly to be commended for his effort and his accomplishment.

"Saw-ge-mah" (which means "Medicine Man" in the Ottawa Indian tongue) is the story of Hal Adams—his early life in a logging town, his determination to be a doctor, his struggles against financial and paternal opposition, his difficulties in working his way through pre-medical and medical school, his days of interneship and residency, his years of general practice in his hometown, his venture as a specialist in surgery in a large city, his realization of the need for general practitioners even in a metropolis, his building of a large diagnostic clinic, his rise to prominence in the field of medicine, his physical breakdown from overwork, his vacation in Europe, and his final return to general practice in the town of his birth. And through it all is woven the story of those women who played so prominent a part in his life—his mother, his childhood sweetheart, his fiance who was so tragically

killed, his wife, and his sister-in-law.

Written by one who knows whereof he speaks, this is as true a story of a physician as one could find. Nowhere does one meet the melodramatic and the sensational which so frequently surround the doctor in fiction and on the screen. Nowhere does one see the cold, grasping, unsympathetic creature which some would have the public recognize as the doctor of today. Instead, the physician is pictured as a normal, hard-working individual—with his strength and his weakness—who, having set his eye upon the goal, refuses to be downed until the end has been achieved.

At a time when medicine and physicians are the topic of so much discussion, this book deserves wide reading.

The second book, "A Century of Medicine in Jacksonville and Duval County," (2) comes from the pen of one of our near neighbors and colleagues, Dr. Webster Merritt of Jacksonville, Florida. Thoroughly documented, well illustrated, and written in a clear and interesting style, it is a credit to the author, and we extend our hearty congratulations to Dr. Merritt for a job well done.

Among the subjects which the author discusses are; the devastating epidemics of yellow fever and smallpox, the toll of malaria, the appearance of cholera in 1866, the part which Jacksonville physicians played in the War between the States, the struggles of the post-war period, the visit of General Robert E. Lee to Jacksonville in 1870, the founding of the Florida Medical Association, the rise and fall of the Florida Medical School, the year in and year out fight for better sanitation.

This book should be welcomed by any physician who has a yen for medical history, and particularly by the physician in the South.

(1). Published by Northland Press, St. Paul, Minn.

(2). Published by University of Florida Press, Gainesville, Fla.

THE TEN POINT PROGRAM

M. L. MEADORS, DIRECTOR OF PUBLIC RELATIONS AND COUNSEL

THE GRIEVANCE COMMITTEE*

*Editorial from the Texas State Journal of Medicine, December, 1949.

The problem of professional self-discipline within the medical profession has always been difficult and has been highlighted among criticisms directed toward the medical profession in the past several years. Several state medical associations have attempted to remedy this situation by providing for a statewide committee to hear and investigate complaints made against doctors by the public, thus augmenting the program of self-discipline of the county medical societies and assisting the boards of censors of these societies. Such a state committee acts more or less as a grand jury whose function it is to investigate, advise, and prosecute if necessary before the proper judicial body, be it county medical society through the board of censors, the board of councilors of the state association, the board of medical examiners, or a civil court in extreme cases in which such action is deemed justifiable.

The first state medical association to develop such a plan, so far as we are able to discover, was the Colorado State Medical Society. Realizing the need for some more effective means of answering the criticism of the public relative to alleged overcharging and negligence of patients and at times charges of malpractice, the Colorado society amended its constitution and by-laws to provide for a Board of Supervisors consisting of twelve members of the society, none of whom hold any other office in the state or county societies of which they are members, and with no two members of the board from the same county medical society. This "grand jury" serves in a completely impartial manner made increasingly so by the fact that any member of the board who is a member of the same county society as the doctor under investigation becomes disqualified for any participation on the board in that particular case.

The functions of the Board of Supervisors are as follows:

1. To receive complaints from anyone—doctors, laymen, hospitals, organizations, medical society staff members—about any dissatisfaction in the medical field.

2. To investigate facts in the case.

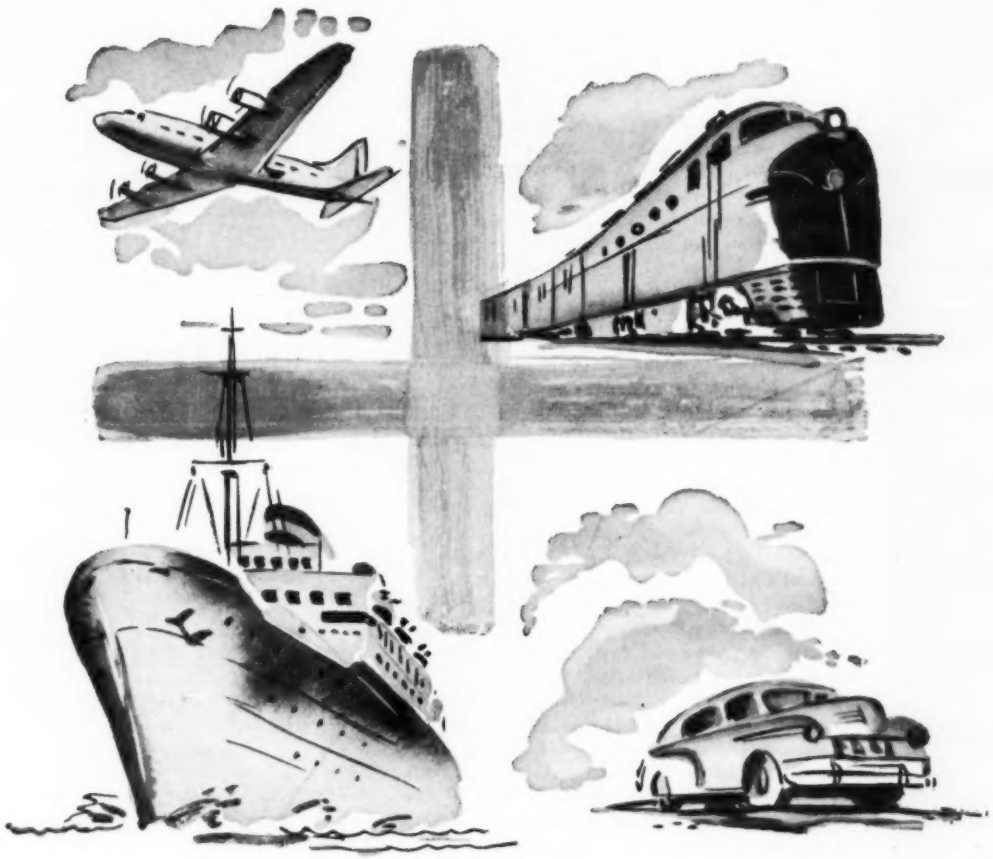
3. To attempt to mediate the dispute and effect a settlement which is mutually satisfactory to complainant and defendant.

4. To prosecute the case before a proper judicial body if necessary.

5. To carry on a continuous intra-society educational program on medical ethics and patient relations, primarily through personal appearances of board members at county society meetings.

A somewhat similar plan has been established by the Oklahoma State Medical Association in the past year. The group within the state association to which complaints are referred is called the Grievance Committee and consists of the five immediate living past presidents of the association. The objectives and methods of procedure are similar if not the same as those of the Colorado plan, as is true with the plans of the four or more other state medical associations which have followed the lead of Colorado.

The fact that the names of the members of the



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Grievance Committee are known to the public and that these men are held in high regard and have the confidence of both public and profession because of the lofty position they have previously held in their medical organization produces a feeling of assurance that impartial justice will be had.

The Colorado plan, which has been in operation for two years, and the more recently established Oklahoma plan both have received high praise through editorial comments in the press and by members of the laity and members of the medical profession. Apparently both of these plans have been eminently successful thus far and neither board nor committee has encountered any difficulty it could not cope with satisfactorily.

The majority of complaints received have been due to misunderstandings which have been easily settled by bringing the doctor and the patient together to talk over the difficulty. Often these misunderstandings have been due to failure on the part of the doctor to explain the nature of his charges; the place of laboratory, roentgen-ray, and hospital charges; charges of the anesthesiologists; the cost of drugs; and so forth, which enter into the total cost of a specific illness. It is pointed out that by a little more diligence on the part of the doctors many of these difficulties can be avoided. Some of the types of complaints other than those arising from a belief on the part of the patient that he has been overcharged are the following: unjustified complaints of psychopathic persons or of "dead beats," ungentlemanly conduct of doctors in public, undue familiarity with female patients, public scandals, criminal abortions, unfavorable results from supposedly wrong diagnosis, performance of unjustified surgery, refusal to answer emergency calls, neglect of patients, and malpractice of different kinds.

At the recent clinical session of the American Medical Association held at Washington, D. C., the House of Delegates commended those states that have grievance committees and recommended that all state medical associations which have not already done so investigate the advisability of forming such committees. The Board of Trustees of the State Medical Association of Texas has had such a plan under advisement for some time and has referred the matter to the Committee on Public Relations for study. No doubt a report will be forthcoming in the near future.

REPRESENTATIVES OF AMA VISIT STATE OFFICE

On April 3rd, by previous appointment, Mr. D. E. McFadden of the Staff of Whitaker & Baxter, Public Relations Firm in charge of the National Educational Campaign of the AMA, arrived in Florence for work in South Carolina. Mr. McFadden was with us for two days, during which time, in cooperation with the Department of Public Relations, the State heads of thirteen National organizations were contacted in person or by telephone.

The purpose of the conversations was to secure cooperation from the head State officials in contacting their local units in the various counties and communities of the State to request action by them in opposition to Compulsory Health Insurance.

Without exception, we were given a cordial reception and promise of full cooperation. Letters over the signature of Dr. Roderick MacDonald, President of the State Medical Association, are being sent to the local units calling attention to the action which has already been taken by their organizations at the National level and suggesting similar action on their part. Some of the material is being mailed from Chicago and some from the office of the South Carolina Medical Association. Certain of the State organizations have turned over their mailing lists to us, while in other cases the material is being mailed by the State offices to their local units.

Among the important organizations which are cooperating in this manner are The American Legion, The Veterans of Foreign Wars, The D. A. R., State Chamber of Commerce, The Federation of Women's Clubs, The Business and Professional Women's Clubs, The Farm Bureau, and The Grange.

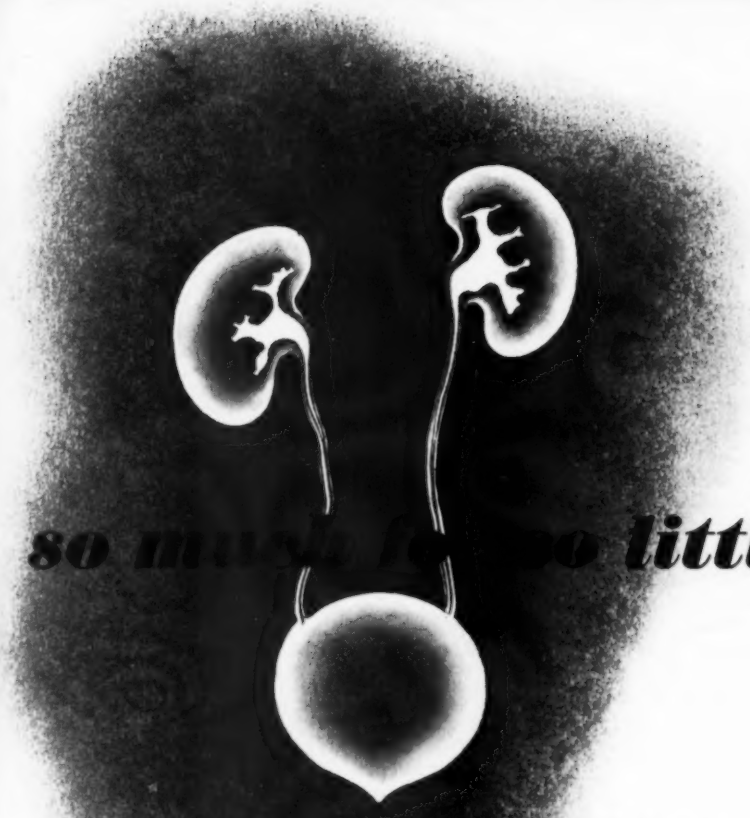
During the week of April 16th the Executive Offices in Florence had the pleasure of a visit from Mr. Lawrence W. Rember, Director of Public Relations and Assistant to the General Manager of the American Medical Association.

Mr. Rember was on a trip to several of the Southern states, contacting their Executive Secretaries and Departments of Public Relations in a spirit of mutual aid and for exchange of information.

Although Mr. Rember brought to us the important information and suggestions with respect to the Public Relations activities of the AMA, he insisted that his primary purpose was to find out firsthand what the States are doing to obtain suggestions for distribution among other States and with the idea of coordinating and disseminating generally work of the various component societies.

A meeting of members of Council and the Public Relations Committees was arranged with Mr. Rember at Florence on the evening of Wednesday, April 19th. On the following evening he attended a meeting of the Pee Dee Medical Society at Conway and spoke briefly to the members of this District organization.

Mr. Rember was impressed with several of the projects undertaken by the South Carolina Medical Association within the past few years, particularly the Ten Point Program. He complimented the Association on the positive approach embodied in this Program and the manner in which it had been formulated, through the combined efforts of individuals and representatives of lay organizations under the leadership of the Medical Profession.



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A DEFINITE THREAT*

Our most dangerous enemy is the bureaucrat or do-gooder who assumes the role of leader, who denies that he is a socialist, and who works behind a smoke screen which he calls National Planning. The social planners have already taken us far down the road which has been the pathway of so many European nations to their regret. Unless we can recognize these individuals for what they are, and can stop them, they will also destroy this country. Their present offering is "security" for the individual or group, but a security which involves too much control, too much surrender of liberty.

John T. Flynn in his latest best-seller, "The Road Ahead" tells of the two great European countries which have become socialist. "Each adopted socialism by a different route. . . . Russia was conquered overnight by a sudden, violent, revolutionary convulsion. Great Britain moved into socialism a little at a time, without bloodshed, in a journey that took almost forty years." We are following Great Britain, and we are much farther along the road than we suspect. They began by advocating a Welfare State.

The British Socialist Prophets of Abundance and Security (the same as ours) have been in power four years and it is finally dawning on the British people that the realities do not correspond to the rosy promises. Britain has "nationalized" about 25 per cent of her economic processes, but she has "socialized" almost the entire system. The government has nationalized the following: The Bank of England (credit); cables and wireless (the overseas communications system); civil aviation; railways, bus transport and inland waterways; coal mines, electricity; the gas industry; medical services.

This socialistic system is able to go on only because it receives untold billions in aid from private enterprise America. The socialists' great hold on the people is because of the social service they promise the people, and which they provide from the cradle to the grave. These services include all medical services, hospital services, old age retirement payments, unemployment pay and allowances for widows and orphans.

Men between the ages of eighteen and fifty, and women between the ages of eighteen and forty cannot change occupations at will, for the Minister of Labor has the power to direct workers to the employment he considers for the best national interest. That power is essential in the controlled economy of the Welfare State.

America is now threatened with this same type of socialism, and just as it fastened itself on Great Britain by a devious movement not called socialism, so it is being fostered in America by persons and organizations who abhor the word "socialism."

*Editorial from The Journal of the Michigan State Medical Society, March, 1950.

SURVEY OF PHYSICIANS' INCOMES

Late in April the Bureau of Medical Economic Research of the American Medical Association and the Office of Business Economics of the U. S. Department of Commerce were scheduled to jointly conduct a survey of physicians' incomes.

The Bureau has been authorized by the A.M.A. Board of Trustees to cooperate in this survey, which the Department of Commerce had planned to conduct alone. It will be the first full-scale survey by the department of physicians' incomes since 1941.

An analysis of the results will be published by the Department of Commerce next fall in its monthly publication, "Survey of Current Business." Its August 1949 and January 1950 issues had published similar analyses of surveys of incomes of dentists and lawyers, respectively, made jointly with the American Dental Association and the American Bar Association.

There is evidence that the national averages in some surveys have been too high because physicians who do not have bookkeepers to fill our questionnaires do not reply in sufficient numbers. Accordingly, the Bureau emphasizes the importance of all doctors, especially those with a relatively small practice, filling out the questionnaires.

Accurate postwar data on physicians' incomes is badly needed in order to develop better estimates of how much the American people pay to physicians.

Every physician can be assured that the survey has no relation whatever to the operations of the U. S. Bureau of Internal Revenue. There is no way by which the Department of Commerce could have obtained the needed information from the Bureau of Internal Revenue; hence the questionnaire survey.

There will be two questionnaire forms. The Bureau of Medical Economic Research helped to design these. A short form will request income data for 1949 only. A long form questionnaire will cover the years 1945 through 1949. All are to be returned unsigned in franked envelopes.

The punch card files of the Bureau of Medical Economic Research contain the names of about 200,000 physicians. The survey will cover 125,000 of these, or 62½ per cent of the total. Selection will be by a formula which eliminates any partiality.

A short form will be sent once only to *every other* name in the file. Of the remaining 100,000 names, every fourth will be selected. To these will go 10,000 short forms and 15,000 long forms, with this distinction—the return franked envelopes will carry a code number which will identify the physician to the Bureau of Medical Economic Research alone. All of the addressing will be done in the headquarters of the A.M.A.

The sole purpose of the code number is to enable the Bureau of Medical Economic Research to address a follow-up letter to those not replying to the first request. Physicians need have no suspicion about the

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code number because when the reply is received, the questionnaire will be separated immediately from the envelope and the identity will be lost.

Physicians will be doing the medical profession a service by filling out the forms and returning them as soon as possible.

POLLS SHOW STRONG OPPOSITION TO SOCIALIZED MEDICINE

Overwhelming public opposition to compulsory health insurance is registered in three polls conducted by Representatives. Results of the *two polls completed* have been published in the Congressional Record while *about one-fourth* of the last survey has been tabulated.

Rep. J. Harry McGregor of Ohio, sampling his district on this and other subjects, found that only *10 per cent* of the people wanted socialized medicine. Mr. McGregor asked 12 questions, including: "Do you favor any type of federal legislation placing the medical and dental profession and operation of our hospitals under Federal control?" *Two thousand* replies were received. Mr. McGregor does not give the numerical totals but lists the replies as ten per cent yes, 90 per cent no. A breakdown by professions shows *opposition from 99 per cent of the businessmen, salesmen, professional and retired people.* Next in line in opposition were housewives 98 per cent opposed; farmers 97 per cent and attorneys and barbers 96 per cent. Socialized medicine had its strongest support among school teachers, 12 per cent of whom answered yes.

A similar survey by Rep. Thomas E. Martin of Iowa showed only about *14 per cent* in favor. Mr. Martin sent out approximately *25,000 questionnaires* and received *4,221* replies, regarded as an ample proportion for a reliable sample. Among 18 questions he listed this: "Do you favor socialized medicine?" Responses totaled 575 yes and 3, 409 no. Significantly both of these districts are almost evenly divided between *rural and urban residents.*

Of the *95,000* questionnaires Rep. Henry J. Latham of New York, sent, *20,000* have returned thus far but only *5,000* tabulated. In his Queens district only *13 per cent* of those tabulated answered yes to the question: "Do you favor socialized medicine?"—753 answered yes, 4,424 no. A second question read: "Do you favor a national health program which would not socialize health services but would supply Federal grants and aids to the States and communities for health purposes?" On this 3,009 said yes and 2,136 answered no.

HOSPITAL CONSTRUCTION PROGRAM IN TROUBLE

The Hill-Burton Hospital Construction Act, which supplies communities with up *to two-thirds* of hospital costs, is running into trouble in two directions:

1. According to Public Health, the country's hospi-

tal construction schedule will be set back an *estimated 12,000 beds next year* if the economy action of the House Appropriations Committee is sustained.

The committee set the 1951 appropriation at 75 million dollars, just half that for the current fiscal year. An effort will be made in House and Senate to get this figure back to 150 million dollars. Meanwhile, *worried state officials are putting in calls to Washington* to learn how they stand. Public Health Service tells us that even if the budget stays at 75 million dollars, only two states actually will be *in the red*, facing obligations they can't meet. However, the troubles just start at this point. Both PHS and the states have been *encouraging* communities to go ahead full speed with fund-raising and other preliminaries, in anticpiation of certain Federal help. As a result, a number of states will be called on to bail out local communities. South Carolina is an example of a tight situation. If the appropriation goes up, this state will have an adequate account to draw on. If it stays at 75 million, South Carolina will have only half as much Federal help and may find herself *overextended*. And this does not take into account those South Carolina communities which are rolling ahead with hospital plans but which have not received formal approval. *They would just have to wait.*

However, Committee members here stated that the 75 million dollars is enough to satisfy all *contractual* obligations.

2. Whether this year's appropriation is *large* or *small*, the act has demonstrated that it is relatively ineffective in getting hospitals built in the areas where need is admittedly *greatest*.

PHS determined this through a survey which designated various "priority areas," based on availability of hospital facilities. PHS discovered that *low income* areas are lagging behind the rest of the country in applications for grants, and that more applications come from *urban* than *rural* areas.

One of the prime explanations, PHS says, is that many of the neediest cannot afford hospitals; they cannot afford the original construction, nor can they afford to maintain hospitals once built. The maximum Federal contribution has been hiked from one-third to two-thirds (for poorer states) of the construction cost just to stimulate such communities, but this apparently is not the solution. Another explanation is that a high percentage of low-income communities lack both an interest in hospitals and the leadership necessary to get a hospital project under way.

AMA DUES AND THE PUBLIC*

On account of the action of the American Medical Association at the Interim Session at Washington, D. C., in December in establishing dues for the members to pay, the Association has been held up to ridicule by our detractors and the propagandists who are promoting socialization of the country. Therefore, it is a real pleasure to find someone with vision and understanding.

Mr. Joseph Christensen, of the Progressive Cafeterias of Chicago, recently wrote as follows to Earnest E. Irons, M. D., President of the American Medical Society: "I cannot put M. D. after my name, but I can, at least for a while, still put U. S. A. As a consequence please accept the enclosed check for $25.00 as a slight token of regard for my doctor and all his colleagues. These are my "dues" as a citizen, and I hope they will help in your fight against socialized medicine. "A people without guts are soon a nation without guts, and if it should become necessary to remove any part of mine, I want to pick my man and pay his charge without a precinct captain getting his nose in my anatomy."

INTERNSHIPS, RESIDENCES COUNT AS ACTIVE SERVICE

The new uniform standards for intern and residency programs of Army, Navy and Air Force have resulted in some confusion. Under each program an appointment carries obligation to serve a certain period on *active duty*. In some cases this has been interpreted erroneously as active duty *in addition* to the internship or residency period. Actually, *all time* served counts as *active duty*. Thus for a *one-year* internship in a military hospital the officer is required to serve *two years* on active duty, which means one year in the internship and an additional year after completion of the internship. If a one-year internship is in a civilian hospital, three years of active duty are required, or *two years* of service after completion of the internship. Residency training, limited to regular officers, may be served on the following schedule: For one-year residency in a military hospital, *two years'* active duty; *two year* residency, *four years'* duty; *three-year* residency, *six years'* duty. For residencies in civilian schools or hospitals, *six months* to a *year* residency, *three years'* active duty; *two-year* residency, *five years'* active duty; *three-year* residency, *seven years'* active duty. *In all cases, active duty starts when the officer starts the internship or residency.*

*Editorial from The Journal of the Michigan State Medical Society, March, 1950.

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WOMAN'S AUXILIARY
SOUTH CAROLINA MEDICAL ASSOCIATION

President: Mrs. J. L. Sanders, Greenville, S. C. Publicity Secretary: Mrs. Kirby D. Shealy, Columbia, S. C.

INVITATION TO STATE MEETING

MAY 16, 17, and 18th, 1950—Myrtle Beach, S. C.

As a climax to a most successful year in our Auxiliary Work, we now anticipate our Twenty-fifth Annual Meeting at Myrtle Beach, S. C. May 16, 17, 18th. Under the able leadership of Mrs. C. R. F. Baker, President of Sumter Auxiliary and our Hostess Auxiliary, with Mrs. A. C. Bozard of Manning, as Co-Chairman, most interesting plans are going forward.

Mrs. Harold F. Wahlquist, 1st Vice-President of Woman's Auxiliary to the A. M. A. of Minneapolis, Minnesota, Mrs. Robert C. Haynes, President of the Auxiliary to Southern Medical Association, of Marshall, Missouri and Dr. Julian Price, Sec-Treasurer, South Carolina Medical Association, of Florence, S. C. will be our honor guests.

A cordial invitation is extended to the wives of all members of the S. C. Medical Association whether or not they are Auxiliary members. Let us contribute toward making this our banner year in attendance of our Meeting at Myrtle Beach.

THE PRESIDENT

THE PRESIDENT'S MESSAGE

The time for relinquishing the responsibility as President of the Woman's Auxiliary to the South Carolina Medical Association has come and I find that a sadness engulfs me when I realize, as I do at this moment, that close contacts with you must be severed to a great extent.

It is with extreme pride that I reflect on the heights you have attained this year. You have had the true worker's spirit, your enthusiasm and wonderful cooperation have been a challenge to me to hold high the aims and objectives of the Auxiliary. You have been continually in my thoughts and the thing paramount in my mind has been to put over effectively the entire program of the Auxiliary for the good of all.

In summing up the year's work one must look back at the starting point which reminds me of the Oriental proverb, "A journey of a thousand miles begins with a single step." Looking back, I find that the time has been far too short to accomplish many things which I now see that might have been achieved. Our activities have increased our aims and objectives have become more clearly defined; new conceptions of service evolved.

The pleasure of working hand and hand with our President-elect, Mrs. A. F. Burnside, cannot be overestimated. It is my sincere desire that she shall be the recipient of the outstanding concern and cooperation of our wonderful group of Auxiliary women to the same degree as I have been this year. Through the reports of the County Presidents, Officers, and Committee Chairmen a clear picture is given of the growth and development in our state auxiliary work.

Dr. MacDonald's interest and unselfish service to the Auxiliary has been most inspiring through the year. I am deeply grateful to the South Carolina Medical Association for the fine cooperation with the Auxiliary, and its liberal financial support which has enabled us to attain worthwhile goals. The confidence placed in us by the Medical Association gives a feeling of pride and that we are a part of the Association, rather than simply an Auxiliary. I feel that this added confidence has not been misplaced.

This report will not be complete if I omit an expression of appreciation to our Advisory Council—Dr. A. F. Burnside, Dr. Archie Sasser, Dr. R. M. Hope, Dr. E. O. Hentz, and especially Dr. J. D. Guess, our Chairman, for his valuable counsel at all times and his able assistance in promoting our Maternal Welfare project, of which he was the instigator. To Mr. M. L. Meadors and Mrs. David F. Adcock for their fine work on our quarterly bulletin, which has brought special recognition to the Auxiliary, and to Dr. Price for space allotted us in the Journal I am especially grateful. Mrs. Claude G. Watson, secretary to Dr. Price, has been most cooperative in working with our publicity committee, and her assistance is sincerely appreciated.

To each County President, Officer, Chairman, and member I am grateful, for it is through your many hours of work and interest that this year's achievements were made possible. It is a distinct privilege and honor to serve as president of the Woman's Auxiliary, and it is my hope that the Auxiliary's support and cooperation has met the full expectation of our parent organization in up-holding the ideals of American medicine.

To our incoming President, Mrs. A. F. Burnside, I wish to pledge our continued cooperation and support and wish her every success in her administration.

MRS. J. L. SANDERS

OFFICERS AND CHAIRMEN

As our Auxiliary year comes to a close it is of paramount importance that those of you who are serving in the capacity of Officers or Chairmen, should have everything organized and in order to pass on to your successor, therefore, enabling her to continue the work more efficiently where you left off.

All material transferred to your successor should be in order, complete with details regarding the activities and accomplishments of the past year, for this I shall be grateful to you.

The President

"ANNOUNCEMENT"

The 27th Annual Convention of the Woman's Auxiliary to the Americal Medical Association in San Francisco, June 26-30th, 1950.

A most cordial invitation is extended to all Auxiliary Members, their guests and to guests of physicians attending the Convention to participate in all the social activities and attend the general sessions of the Auxiliary.

CHARLESTON AUXILIARY

Mrs. Clay W. Evatt was installed as president of the Charleston branch of the Woman's Auxiliary to the South Carolina Medical Association at its annual luncheon meeting at Henry's restaurant. She succeeds Mrs. Bachman S. Smith, Jr.

Other officers elected were Mrs. D. W. Ellis, president-elect; Mrs. Vince Moseley, vice-president; Mrs. George H. Orvin, secretary, and Mrs. Phillip S. Cro-

The Protein-Rich Breakfast and Morning Stamina

Extensive studies* by the Bureau of Human Nutrition have established that breakfasts rich in protein and supplying 500 to 700 calories, effectively promote a sense of well-being, ward off fatigue, and sustain blood sugar levels at normal values for the entire morning postbreakfast period.

These physiologic advantages are related mainly to the protein content rather than to the caloric content of the breakfast. In fact, when isocaloric breakfasts were compared, those with the higher amounts of protein led to the greatest beneficial effects. Breakfasts providing the lower quantities of protein (7 Gm., 9 Gm., 16 Gm., and 17 Gm. respectively) produced a rapid rise in the blood sugar level and a return to normal during the next three hours. Breakfasts providing more protein (22 Gm. and 25 Gm. respectively) produced a maximal blood sugar rise which was lower than that following the breakfasts of lower protein content, but the return to normal was delayed beyond the three hour period.

The subjects on the higher protein breakfasts "reported a prolonged sense of well-being and satisfaction." The findings indicated that the beneficial effects of the high protein breakfast on the blood sugar level may extend into the afternoon.

Meat, man's preferred protein food, is a particularly desirable means of increasing the protein contribution of breakfast. The many breakfast meats available are not only temptingly delicious and add measurably to the gustatory appeal and variety of the morning meal, but they also provide biologically complete protein, B-complex vitamins, and essential minerals. *Meat for breakfast, a time-honored American custom, is sound nutritional practice.*

*Orent-Keiles, E., and Hallman, L. F.: The Breakfast Meal in Relation to Blood-Sugar Values, Circular No. 827, United States Department of Agriculture, Bureau of Human Nutrition and Home Economics, Agricultural Research Administration, Dec., 1949.

The Seal of Acceptance denotes that the nutritional statements made in this advertisement are acceptable to the Council on Foods and Nutrition of the American Medical Association.

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mer, Jr., treasurer. Mrs. T. Willard Reynolds, Jr. served as chairman of the nominating committee.

Delegates to the state meeting to be held at Myrtle Beach, May 16-18 were elected as follows: Mrs. William W. Speissegger, Mrs. John van de Erve, Jr., Mrs. Richard W. Hanckel, Jr., and Mrs. I. Rippon Wilson, Jr.

Alternates elected were Mrs. Robert Wilson, Jr., Mrs. Ellis, Mrs. Evatt and Mrs. Robert M. Hope.

Mrs. J. L. Sanders of Greenville, state president of the auxiliary, was guest speaker at the meeting. Her husband, Dr. Sanders, was also a guest. Mrs. Sanders was introduced by Mrs. Robert Walton, program chairman.

The speaker gave a review of the origin and aims of the national and state auxiliaries and emphasized the need for keeping informed on current legislation pertaining to the medical profession. She suggested that the Hygeia magazine be more widely distributed in the community and concluded with the state auxiliary's slogan for the year, "Information Breeds Interest."

Mrs. Smith, retiring president of the branch gave her annual report, highlighting the accomplishments of the group during the year.

ANDERSON AUXILIARY CELEBRATES DOCTOR'S DAY

Special tribute was paid to the memory of the late Dr. J. O. Sanders of Anderson and the late Dr. W. R. Hayne of Belton by the Anderson County Medical Auxiliary on March 30. All doctors in the county were presented red carnations to wear on that day.

Later, a dinner was given at the Country Club for the doctors and their wives. Entertainment following the dinner was an hilarious local talent show put on by the doctors themselves. Sixty-five doctors and their wives enjoyed the party which was planned by a committee composed of Mrs. S. Harry Ross, chairman, assisted by Mrs. Wilson Ratcliffe, Mrs. J. N. Land, Mrs. Clyde Bowie, and Mrs. Sarah Harris.

DOCTOR'S DAY IS OBSERVED IN PEE DEE

"Doctor's Day" was observed throughout the Pee Dee area by the members of the Pee Dee Medical Auxiliary. This year the special day was observed with the presentation of a red carnation to every doctor in every county of the Pee Dee, the flower being pinned on each doctor by a member of the auxiliary.

The red carnation is the official flower of the Medical Society, and was chosen as a fitting token of appreciation to the doctor for his unselfish and unremitting service. Plans were completed for the observance of Doctor's Day, at a meeting of the auxiliary held at the Florence Country Club on March 15.

Mrs. E. B. Michaux of Dillon is president of the Pee Dee Auxiliary, and Mrs. E. C. Hood of Florence will succeed her as president. Mrs. J. D. Smyser of Florence is secretary. She stated that Doctor's Day is a national organization, and has been observed throughout the nation for the past several years.

DEATHS

FLETCHER JORDAN

Just four years ago, some two thousand people gathered at the home of a physician to do him honor. Four hundred of the approximately 3,500 babies he had delivered took part in a parade which preceded the ceremonies of the occasion. Tributes were spoken and a Chrysler car and silver service were presented in token of appreciation for the work which he had and the life which he had lived. Thus did his patients and friends show their affection for a family physician, Dr. Fletcher Jordan.

On March 17, following an illness of two days Dr. Jordan, age 70, died at his home. Another beloved family doctor had laid down his stethescope for the last time.

Born in Tennessee, Dr. Jordan received his degree in medicine at the University of Virginia (1906). Following post-graduate work in this country and England, he entered general practice which he continued up until two days of his death. He is survived by his wife, the former Miss Louise Atkins, two sons and two daughters.

WILLIAM H. WOODS

Dr. William H. Woods, 69, died at his home at Myrtle Beach, March 31, after an illness resulting from a fall last October.

A native of Clarendon County, Dr. Woods received his medical education at the University of Nashville from which institution he graduated in 1905. He then went to England for further study in eye, ear, nose and throat work.

Dr. Woods is survived by two sons, William H., Jr., of Myrtle Beach, and Richard I., of Columbia.

OSCAR L. BRUORTON

Dr. Oscar L. Bruorton of Georgetown, died in Cairo, Ill., March 26, following a heart attack. He was accompanying his daughter to St. Louis when he suddenly was stricken.

Born in Georgetown County, July 28, 1885, Dr. Bruorton was graduated from the Medical College of the State of South Carolina in 1912. Following graduation he practiced medicine in Georgetown County until he entered the army and served as a captain in the medical corps during World War I. After the war he returned to Georgetown where he practiced until several years ago.

Dr. Bruorton is survived by his widow and one daughter.